REPORT RESUMES

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NEW TECHNIQUES IN DIAGNOSIS AND APPRAISAL AND IMPLICATION FOR THERAPY FOR ALL PUBLIC SCHOOL CHILDREN WITH COMMUNICATION DISORDERS, PROCEEDINGS OF A SPECIAL STUDY INSTITUTE (OCTOBER 4-6, 1967, MONTGOMERY, ALABAMA).

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IN OCTOBER, 1967, A SPECIAL STUDY INSTITUTE, SPONSORED BY THE ALABAMA STATE DEPARTMENT OF EDUCATION, CONVENED FOR THE PURPOSES OF (1) DISCUSSING THE MOST EFFICACIOUS MEANS OF SPEECH THERAPY PROGRAM ORGANIZATION, (2) EXPLORING NEW TECHNIQUES OF SPEECH PROBLEM IDENTIFICATION, PROGNOSIS DETERMINATION, AND THERAPEUTIC SEQUENCE DEVELOPMENT, AND (3) STUDYING THE ROLE OF THE SPEECH THERAPIST IN RELATION TO THE TOTAL PUBLIC SCHOOL PROGRAM. REMARKS BY LUCY WHITLEY CONCERNED "PTA'S ROLE IN ASSISTING SCHOOLS IN PROVIDING SERVICES TO CHILDREN WITH COMMUNICATION PROBLEMS." THE FOLLOWING PAPERS WERE PRESENTED--(1) "THE RESPONSIBILITY OF PUBLIC SCHOOLS IN PROVIDING SERVICES TO CHILDREN WITH COMMUNICATION PROBLEMS" BY W.W. ELLIOTT, (2) "TECHNIQUES IN DIAGNOSIS AND APPRAISAL OF CHILDREN WITH COMMUNICATION PROBLEMS" BY GRETCHEN PHAIR, (3) "CHANGING CONCEPTS ON COMMUNICATION PROBLEMS--IMPLICATIONS FOR THERAPY" BY GRETCHEN PHAIR, (4) "THE ROLE OF SPEECH THERAPIST IN THE PUBLIC SCHOOLS" BY MARTHA BLACK, (5) "SOME MEDICAL ASPECTS OF SPEECH PATHOPHYSIOLOGY" BY WILLIAM DANIEL, JR., (6) "COMMUNICOLOGISTS IN THE TOTAL HEALTH PICTURE" BY GWENYTH R. VAUGHN, AND (7) "ORAL ARCHITECTURE AND EXPRESSION POTENTIAL" BY JOSEPH M. SIMS. SUMMARIES OF TWO GROUP SESSIONS AND A LIST OF PARTICIPANTS ARE INCLUDED. (JB)

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NEW TECHNIQUES IN DIAGNOSIS AND APPRAISAL AND IMPLICATION FOR THERAPY FOR ALL PUBLIC SCHOOL CHILDREN WITH COMMUNICATION PROBLEMS

PROCEEDINGS OF A SPECIAL STUDY INSTITUTE

STATE DEPARTMENT OF EDUCATION
PROGRAM FOR EXCEPTIONAL CHILDREN AND YOUTH

ERNEST STONE
STATE SUPERINTENDENT OF EDUCATION
MONTGOMERY, ALABAMA

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NEW TECHNIQUES IN DIAGNOSIS AND APPRAISAL AND IMPLICATION FOR THERAPY FOR ALL PUBLIC SCHOOL CHILDREN WITH COMMUNICATION PROBLEMS

PROCEEDINGS OF A SPECIAL STUDY INSTITUTE

MONTGOMERY, ALABAMA

OCTOBER 4-5-6, 1967

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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FOREWORD

A Special Study Institute, New Techniques in Diagnosis and Appraisal and Implications for Therapy for All Public School Children With Communication Problems was held at the Whitley Hotel, Montgomery, Alabama, October 4, 5, 6, 1967.

This Institute was directed toward speech therapy for exceptional children with these purposes in mind:

1. To discuss the most effective means of program organization to benefit the greatest number of children with maximum efficiency.

2. To attempt to bring together new techniques in identification, in determining prognosis, and in developing an advantageous therapeutic sequence for children with communication problems.

3. To study the role of the speech therapists relation to the total public school program.

The public schools are being called upon more than ever before to provide speech therapy for exceptional children and youth. Many of these children have received speech therapy from hospitals and private clinics but because of the expense and transportation problems involved a large majority of our students with communication problems are deprived of speech therapy. Approximately 5% of the public school population has speech difficulties sufficient to require the skill of a speech therapist for correction.

Speech therapy is relatively new as an organized program in the public schools of Alabama. Due to the limited number of speech therapists available to the public schools there has been little opportunity for professional growth and consultative services in the new approaches to implementing speech therapy in the public school program.

It is hoped this Institue will help develop a comprehensive, well-coordinated program in speech therapy.

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PTA'S ROLE IN ASSISTING SCHOOLS IN PROVIDING SERVICES TO CHILDREN WITH COMMUNICATION PROBLEMS

Mrs. Lucy Whitley

Madam Chairman, Ladies and Gentlemen.

It is an honor to be here with you for this Institute. This is one of the pleasurable things about being the State PTA President, you are invited and permited to talk about subjects *dear* to *your heart.* This morning Mrs. Brown asked me to talk a few minutes on PTA's Role in Assisting Schools in Providing Services to Children With Communication Problems.

If we believe that every child should have maximum opportunities to develop his capabilities to the fullest extent possible, then we cannot be satisfied until all who need special services receive them.

Although commendable gains have been made in provisions for Exceptional Children, there is much to be done for children in Public Schools with communication problems. The PTA has an obligation to assist the schools in providing services for children in Special Education classes. They should work closely with the educators to promote early school education for Exceptional Children and they should keep the legislators informed about the needs and problems of exceptional children and urge their support on legislation relating to them including adequate finances for this important phase of education, emphasizing the need for additional units for special classes, pointing up the need for more services, such as physical, occupational and speech therapies.

PTA members should cooperate with other agencies to provide children with special opportunities for developing creative talents, such as art, music and theater groups. In addition they should offer their services to relieve special education teachers in the classroom for short periods *(daily)* to allow the teachers free time to plan or just to take a rest period. The State PTA has an Exceptional Child Standing Committee Chairman. This chairman is encouraged to involve all PTA committees in promoting the program and to study ways of projecting information and services for children with communication problems.

Some of these can be *Preschool Service, Program Service, Mental Health* and *High School Service.* The *School Education Chairman* can help to encourage more young teachers to enroll in special education courses in college, and to urge that students and teachers of special education be considered when state and/or local scholarships are awarded. The *Reading* and *Library Service Chairman* should promote wide use of reading material pertinent to this group. To bring a closer relationship between the school and the home and to be able to better understand the schools. *Parent Education Chairmen* endeavor to organize study groups for the parents to meet other parents with the same problems to be able to sit down and talk over the problems together. After such an experience they realize they have understanding friends who want to help. Parents of Exceptional Children should be invited and encouraged to *join* the PTA and urged to support and participate in the *PTA program.*

I have been interested in special education for years and have been an admirer of Mrs. Brown and proud of the progress she has helped to make possible in special education in the public schools in Alabama. I have had some experience working with exceptional children in special education classes, but being surrounded by so many professionally trained experts at this institute tend to make me realize my inadequacies; however, I intend to listen to everything that is said so I may learn new techniques to be better prepared to help in special education classes in future. And in addition I pledge you the support of the Alabama State PTA for the next two years ahead.

Thank you for inviting me to be with you.

RESPONSIBILITY OF PUBLIC SCHOOLS IN PROVINDING SERVICES TO CHILDREN WITH COMMUNICATION PROBLEMS

Dr. W. W. Elliott

Mr. Chairman, Ladies and Gentlemen:

I assure you that I consider it a great honor to have been invited to speak to this outstanding group of professionals. At no time, in our nation, have educators been so involved and buffeted by the conditions surrounding them in American society. Once the problems which faced our society did not invade the area of school administration as they do now, and we were left relatively unaffected as we performed our professional responsibilities. Today, these problems are brought into the school, and we are asked to find solutions. We are called upon to provide increased educational opportunities for an ever-larger number of students from every background. We are called upon to examine the rapid accumulation of new knowledge and new information about how children learn. We must meet the basic, universal, and continuing human need for a sense of individual worth and identity. Every student needs to develop confidence that he matters, that he is somebody.

We must provide conditions so that the individual can develop the personal resources necessary to maintain his individuality in a mass society which demands increasing conformity. As we try to teach more, and faster, we must not lose sight of the individual. It is for this particular reason that we have assembled ourselves here at this institute to study the problems, special problems of individuals which we find in our society. Sometimes, because of the unprecendented rate of change in our society, we are thrown off-balance. As administrators and teachers, we are found trying to develop ways of coping with our new social problems resulting from rapid change. The stabilizing influence traditionally provided by other social institutions in periods of normal change are lacking because they, too, are caught in change. The problems which we face in education are a part of the fabric of our society, and those of us in public education cannot solve them alone, but we can give the leadership needed to bring about new innovations and developments to meet the particular needs of every individual child in our schools. The very best we did yesterday will be even less acceptable tomorrow.

School systems throughout the country are recognizing to an increasing degree their responsibilities to all the citizens in their community — the bright and the dull, the old and the young, the exceptional and the so-called average student. The nation, as a whole, is committed to making the best use of the talents of *all* its citizens. Indeed, its strength lies in the full development of the capabilities of all the people by opening the doors of opportunity to the handicapped as well as to the more fortunate. During the pre-Christian era, handicapped human beings were persecuted, mistreated, and neglected. As Christianity spread, they were pitied and protected. In the last 150 years they have gradually become accepted and integrated into the main stream of life. The past 15 years have witnessed a dramatic, psychological shift in public opinion. We no longer view the handicapped as deficient individuals. We now emphasize their actual potentialities for self-fulfillment.

A significant force behind the recent development of opportunities for the education of exceptional children has been state legislation. By 1948, a total of 41 states and the District of Columbia had enacted legislation for special education in local school systems. Only 34 had made provisions for financial participation on the part of the state for the maintenance of these programs. Today, all 50 states have such legislation.

Those of us who have the privilege of living in the great State of Alabama will always owe a debt of gratitude to those great stalwarts in public education who had the foresight, some fifteen years ago, to begin a study and to make plans for legislation which would provide education in the public schools of Alabama for the exceptional child. As a result of this legislation, we are on the road to a realization of the dreams envisioned by these great people. I need not recall to your attention the reluctance on the part of many school administrators and lay citizens in our communities to accept the responsibility in the public schools for the education of the exceptional child, and particularly of those who were physically or mentally handicapped. May I remind you, however, that this is not the only innovation in public education that has been slow in its acceptance by the people of our communities. We could mention many; but to illustrate, may we just mention one or two programs which, in the days many of us attended elementary schools, would have been impossible to have inaugurated in our schools. We certainly could never have received financial assistance from the public for the support of them. The public school - lunch program was almost unheard of in our area in the late twenties and early thirties; and when it came to providing capital funds for the construction of kitchens and serving areas, it was absolutely out of the question. The furnishing of free textbooks at public expense was not acceptable to our people until within the last five years.

We could go on and on listing great improvements in public education which have come about as the result of the efforts of dedicated people like you who are assembled for this conference. I am sure that each of you realizes that administrators, alone, cannot do the job. They can give some leadership, but it takes dedicated professional people such as you to assist in pointing the way to our lay citizens so that they will accept their responsibilities for meeting the needs of all our children.

Dr. Paul Mort, a great educator and professor at Columbia University, used to state, before his death, that past experience would indicate that the American public need nev[illegible] fear the too rapid spread of *any* educational idea or invention. He went on to say that it is startling [illegible]hen one's attention is called to the slowness with which new educational practices are adopted by American school systems. From his study of the "lag theory," Dr. Mort concluded that the period of diffusion for educational adaptation would average 50 years. He found the introductory period was one of slow trial on the part of educational pioneers. This period seemed to last until approximately three per cent of the schools adopted an educational practice; this seemed to require at least 15 years. The early introductory period is followed by a period of rapid diffusion as the adaptation spreads through a majority of school systems. The diffusion period slows down again during the latter stages — a period of convincing the laggards of the desirability of adopting the practice. It is my belief that we are in the bright period of adaptation on the part of all of our people as far as their being concerned about providing the best training available for all the children of all the people. To illustrate our stepped up tempo in the training of teachers who work with children with communicative disabilities, may I cite a few figures of comparison. In 1949, 77 institutions of higher education reported sequences of courses (including summer session sequences) in the several areas of exceptionality. Included in the 77 programs reported were 17 in the deaf area, 25 in hard-of-hearing, and 66 in speech-handicapped. In 1953-54, a comparable report was published. At this time, the number of institutions increased from 77 to 122 who reported complete sequences, exclusive of summer session programs, an increase of 45 collegiate programs within a five-year period of institutions that had inaugurated programs of teacher-training for the several areas of exceptionality. Those training hard-of-hearing teachers had increased from 25 to 68, a gain of 43; those training teachers of the deaf, from 17 to 22, a gain of 5; those training speech therapists, from 66 to 115, a gain of 49.

During my experience as a school administrator, it has always been a joy and a delight to me to have the opportunity to visit classes in the system in which work was being done with the problems of handicapped children. There have been times when, after a series of visits, I would go home in the evening from a long day's work quite frustrated and tired and wondering just what we were accomplishing for these children. Sometimes there seems so little change from one day to the next, one week to the next, or from one year to the next; but then I always come back to this idea for the solution to my frustration and my problem. If this teacher, whom I visited today, makes it possible, this year, for *one* individual in her class to live independently, to live a more purposeful and happy adulthood, and make his contribution to our American democratic society, limited though it may be; then all who have made a contribution in the development of this program will be repaid in full measure. A few years ago through cooperation with the University of Alabama we started classes for the children who had hearing difficulties in our community. We would have never begun such a program without having had expert and professional advice available to us on these matters. Having secured a teacher and having this professional counsel available, we started classes for these children. The acceptance of the program and the public response to the needs of these classes has been phenomenal. The inquiry from distant communities of parents who were willing to move their families to our community in order to enroll their young children in these classes have been quite touching to all of us. We believe that it is reasonable to conclude that handicapped children should have the benefit of their families and of the parents. Children need the security of their homes, and this need is oftentimes intensified in the presence of a disability. We believe that contacts of a social nature with non-handicapped of their own age and of their own interests are important to these children. We believe that it is important to the growth and development of handicapped children that they be integrated into the regular curriculum whenever educationally possible during the school day. Two logical areas for integration would be in the school-lunch program and in health and physical education activities. It seems to me that this would be more important to children with communication disabilities than in any other area of exceptionality. By integrating these children as much as we possibly can into the regular program, we can improve the mental health concept and perhaps remove some of the stigma that is often associated with institutionalization. We believe, also, that we are in a position to give these children the services of highly-trained teachers and other service personnel which many times are not available under other conditions.

Our community has provided the highly technical instruments and hardware needed for these classes without complaint. Our school system, now involved in an extensive program of construction, is building classrooms for the hard-of-hearing, the mentally retarded, and for the speech therapists. Our need to communicate with our fellowman is possibly our greatest need; and the fulfillment of all our other needs and desires is largely dependent upon, or at least greatly facilitated by, our ability to satisfy this basic want. The development of language, both spoken and written, as a means of communication is one of mankind's greatest achievements. During the past two years it has been my pleasure to go abroad on three different occasions, and on each one of these trips, I have made it a point to do my best to find an opportunity to look at programs of education for the handicapped. A month ago I was in Guatemala City and I visited what they call their Neurological Clinic, a project made possible by the ingenuity and humanitarian efforts of an American-trained Guatemalan doctor. As I recall, he had about 100 children in this institution with all types of physical handicaps. He introduced me to the first speech therapist who had been employed in their country. She had been trained in Argentina and was attempting to work with the children who had communication difficulties. Yet, here I was, unable to get much information so that I could understand the problems of the handicapped in Guatemala because the language barrier made it impossible for me to communicate. This personal experience gave me an insight, at least to a small degree, to some of the frustration experienced by a person who has never been able to hear or speak well. From birth we have absorbed these magnificent tools effortlessly, almost unconsciously, simply because we are lucky enough to hear and to speak. We take it very much for granted and tend to belittle, to shun, or to look somewhat askance at anyone who has had to fashion, bit by bit, word by word, sound by sound, a workable, even though imperfect, language tool for himself. I recall hearing William Gargan of radio and television fame tell of his problem when cancer attacked his larynx and it became necessary for him to undergo surgery and his ability to speak taken from him. He said he thought to himself, "Oh, God, why me, when I am so dependent upon my voice for a livelihood and for communication?" When I heard him speak in Chicago in 1963, he said that he had changed this attitude since by learning to breathe and exhale air, he could once again communicate with other people by making distinguishable sounds to the extent that he was addressing us from the stage of the Palmer House Ballroom. He said, "Now it is not, 'Oh, God, why me?' but "Oh, God, why not me?' because I have been in a position to influence and encourage so many people who have had similar problems to mine and who had completely given up."

My friends, there is a great challenge to all of us to meet these human needs of our people. I believe that with all the technological developments in the years ahead we are going to be able to eradicate many of the ills which now affect the educationally exceptional child. It seems to me that the trends indicate that the provision of needed educational opportunities and facilities will rise sharply during the next few years now that people have come to accept this as a responsibility of the public schools. I believe that every child will have the advantage of going to a school where he, too, can be a part of an active, satisfying experience of growth. Ways will be devised for using a wide variety of media, some of which are not yet available, for a great extension of the eyes, ears, minds, and muscles of these children. Steps will be taken to identify and to ameliorate children's impairments at an early age. Provisions will be made for older youth and adults as opportunities are extended for continued development. New modes of travel and communication systems will make possible the school attendance and the provision of home services to children in the most remote localities. If wise political, economic, and social decisions continue to raise the level of the abundant life, facilities and opportunities resulting from research and development will appear for which there are no present dreams.

In the words of Benjamin Willis, former Superintendent of Chicago City Schools, let me say that special education is the story of a journey out of retreat from life into the light of undiscovered abilities. It is the contentment, and then the confidence, and then the courage that comes with accepting that we do not all begin at the same place. It is the inner challenge to each to begin with his own today as he builds for his tomorrow.

TECHNIQUES AND DIAGNOSIS AND APPRAISAL OF CHILDREN WITH COMMUNICATION PROBLEMS

Mrs. Gretchen Phair

Introduction:

I am pleased to be here and to see several familiar faces. I hope that what I have to offer may be of help to us in helping children who have problems in communicating.

The framework for this speech is a review of a case record — a case report — a diagnostic report — or a cumulative speech and hearing record (call it what you will) with emphasis on certain aspects of diagnosis that I feel are important to us. In order to cover the material I would like to cover in the time assigned, we will have to make certain assumptions.

We will assume that you have the necessary identifying information regarding Johnny Appleseed and that the history you have accumulated or are in the process of accumulating includes information regarding the environmental, developmental, physiological and medical, educational, and behavioral aspects pertinent to the case. You have gleaned from the parents, the teacher, the psychologist, the counselor, the school nurse, and the family physician relevant information and are now about to evaluate the child from the point of view of the speech clinician.

We are also assuming that this child was referred to you. If you are in a clinic situation you undoubtedly have preceeded your appointment for the evaluation with a case history form, that asked the parents or the client to describe the problem and give any pertinent information. You have probably used some questionnaire or outline form that will suggest a possible starting point in your evaluation. If you are in a school system you have undoubtedly given the teachers information regarding speech deviations. This information would include explanations and examples of problems so that the teacher might be more knowledgeable in referring children. You may also have suggested that she refer to you the child who is unusually shy, withdrawn, or uncommunicative, who is a poor reader, who avoids speaking in class, and who appears to be hard-of-hearing. In a school system you may also have used some screening devices to choose a group of children from which you will pick your case load.

Our tools of diagnosis are observation (both visual and auditory) and certain tests which we can measure against some normative data. We use developmental norms as much as we can, and we are ever hopeful that predictive or prognostic measures will continue to be developed. We must be sure that the "norms" we are using are applicable to the situation.

Also applicable to the situation is our judgement of the degree of the communication handicap. We must consider the general speech standards of the environment, the importance of good speech for the person's work or social needs, the attitude of the family and friends, the potential influence the speech deviation has on the child, and his feelings about it. We must have some idea of how much the child can do to change the pattern of his speech.

Since articulation appears to be the most common speech deviation, let's begin our evaluation with an articulation inventory. We have used word lists, pictures to elicit speech, reading samples, and tape recordings of spontaneous speech to evaluate the production of the phonemes of speech. Each of us has a preferred way of eliciting the desired response. We do want to know the sounds that the child can produce correctly and those he cannot produce correctly. For those sounds which are incorrectly produced, we want to know how they were produced — were they omitted, distorted, or substituted by another sound (which sound)? Can the incorrect sound be produced correctly some of the time? When we have our completed inventory let's compare it to the study conducted by Wm. F. Hall & Wm. C. Healy and reported at the last ASHA Convention, held in Chicago. Most of you are familiar with the work of Irene

Poole, considered as normal development of speech sounds. This study amplifies that information since it separates the male and female children and does give information regarding the phoneme in initial, medial, and final positions in words. By comparing the child's inventory of speech sounds with these developmental norms we can judge whether or not his articulation is at the same level as the articulation of 90% of the children tested.

We have asked before, can the correct sound be produced some of the time? Dr. Mary Farquhar, reporting in the JSHD, November, 1961, stated that the best predictive test as evidenced by her research at Boston University was whether or not a child could imitate a sound alone, and in words, and syllables. For example, if the child who produced the [s] incorrectly could produce it correctly upon imitation in a group of four sounds (example — m-p-w-s, a-b-s-n) in the nonsense syllables, si, isi, es, or *s*a, a*s*a, a*s*, and in words such as *s*cissors, i*c*e cream cone, hor*s*e, his prognosis for developing the sound normally is good. Milisen & Stone had reported earlier that the prognosis was good if a child could imitate the defective sound correctly in nonsense syllables, 75% of the time. Auditory discrimination was also considered in Dr. Farquhar's study but the tests of auditory discrimination were not of predictive value.

Dr. Charles Van Riper reported on a predictive test of articulation at the ASHA Convention last fall. It is being field tested at the present time. Note that the test consists of having the child repeat certain words containing the phonemes [r] [s] [l] and [z] and the blends of these phonemes. In addition to the words, the child is asked to produce the [s] and [th] and the nonsense syllables — seeseesee, zoozoozoo, puh-tuh-kuh, and la-la-la. He is also asked to follow a clapping rhythm. The cut-off score of this predictive test (according to personal correspondence with Dr. Van Riper) is 30. If a kindergarten child can score 30, he or she will not need special speech help. (I think this means 41 right.)

The Seattle Public Schools have been working on a predictive articulation test, too. Their study should be completed this year and hopefully it will give us some leads for prediction.

Let us turn now to the evaluation of the Speech Mechanism. In addition to the general physical appearance of the head and face, lips, mandible, teeth, tongue, hard palate, soft palate, and larynx, we need an examination for the muscular control for speech.

The items from "Diagnostic Manual in Speech Correction", Johnson, Darley & Spriestersbach, for the examination of muscular control for speech includes sustaining steady exhalation; sustaining steady phonation; opening and closing the mouth; mandible and lips moving together; opening and closing the lips with teeth together; raising tongue tip to gum ridge, mandible stabilized; moving tongue tip from corner to corner of mouth; extending corners of lips from rounded position, teeth together; and peristaltic activity of tongue-propelling foods and fluids posteriorly and swallowing. These items have given us some measurable data, and can be used without a Sylrator. At the University of Wisconsin the normative data for the diadokokinetic rates have been used in assessing the rate and rhythm of the lips, mandible, and tongue tip and back.

Several studies have shown that motor ability does relate to articulation ability. Stanley Dickson's study, *Differences between Children who Spontaneously Outgrow & Children who Retain Functional Articulation Errors,* JSHR, Sept. 1962, used the Oseretsky Test of Motor Proficiency, the Templin Short Test of Sound Discrimination and the Minnesoto Multiphasic Personality Inventory. He found that children who retain speech errors are *inferior* in gross motor tasks to those who outgrow the speech errors.

Jenkins & Lohr, JSHD, August, 1964, reported on *"Severe Articulatory Disorders & Motor Ability."* The definition of a severe articulation defect in this study was the inability to produce acceptably, four or more different consonant sounds as judged by a trained speech correctionist. The Oseretsky tests were used in the study. These items were measured:

1. General Static Coordination, maintaining balance in a given body position for a given period without gross movement of the limbs or torso; for example, standing on tiptoe or one leg.
2. Dynamic Manual Coordination, performing coordinated hand activities as directed within a given time and with accuracy; for example, cutting paper, or throwing a ball.
3. General Dynamic Coordination, maintaining balance while performing a given movement for the whole body; for example, running and hopping.
4. Motor Speed, executing movement within speed and accuracy limits; for example, placing coins in a box.
5. Simultaneous Voluntary Movements, executing given patterns for movement simultaneously with both hands and/or feet; for example, tapping alternately the left and right foot.
6. Synkinesia, performing a given muscular activity without showing any extraneous (overflow) movements; for example, clenching the teeth without wrinkling the forehead.

The results of this study showed that the speech defective group had, on the whole, significantly lower motor-quotients (M.Q.=77) than was the case for the normal-speaking controls (M.Q.=87).

The rate of speech relates to the motor proficiency and influences the intelligibility of conversational speech. Though we are lacking in normative data on rate, some interesting thoughts relative to the judgement of rate were postulated by Dr. John Saxman, University of Wisconsin, in a recent lecture. The ratio of phonation time, to pause time may be critical in this judgement, and the inefficient use of airflow, when a person stops more often to take in air, will influence rate. An interesting report on the effect of rate is reported in Guttman's article, JSHR, September, 1966, *"Measurement of Articulatory Merit"* which discusses the Articulatory Product (A.P.) which converts a bi-dimensional characterization of speech into a uni-dimensional scale. It states that inaccurate speech at a normal rate, is as meritorious as accurate speech at a very low (or very fast) rate. Besides rate, the voice quality, pitch, and loudness are observed acoustically by the speech clinician and reported on our case report to add to the information regarding the child.

Let us now consider some aspects of the language of the child. In the research, "An Equation for Assessing Language Development" by Thomas Shriver and Dorothy Sherman, J.S.H.R., March 1967, samples of speech were used to obtain an equation for predicting the degree of language development as measured by psychological scale values. "If a single measure is to be used for assessment of language development, the most useful of those studied is the mean length of response." We need some count of the sentence length used by the child in a normal situation, and certainly a tape recording would help us here.

Vocabulary is an aspect of language that has been useful in measuring a child's ability. The Peabody Vocabulary Test (Form A or Form B) gives us a Vocabulary Age for the child. This is an untimed test and usually takes no longer than 10 or 15 minutes since the scale is administered only over the critical range of items for a particular subject. The test is designed to measure the hearing vocabulary, since the items are presented orally. According to the test manual it can be given to any English-speaking resident of the United States between 2 years 6 months and 18 years who is able to hear words, see the drawings, and has the facility to indicate "yes" or "no" in a manner which communicates. Among the advantages of this test are: (1) the test has high interest value and is therefore a good rapport establisher; (2) extensive specialized preparation is not needed for its administration; (3)

it is quickly given in 10 to 15 minutes; (4) scoring is completely objective and quickly accomplished in one or two minutes; (5) it is completely untimed and thus is a power rather than a speed test; (6) no oral response is required; (7) alternate forms of the test are provided to facilitate repeated measures; and (8) the test covers a wide range. (IV)

The test consists of 150 numbered plates which are presented to the subject (after three example plates). Each plate has four illustrations. The examiner reads the word and asks the subject to indicate his response. Starting points for each age level are given. A basal (8 correct responses) and a ceiling (6 errors in any 8 consecutive presentations) are established and the vocabulary age is derived from the raw score (total of correct responses) using the tables presented in the manual. Dr. Lloyd Dunn, author of the test, discusses the reliability and validity of the test in his manual. This test does give us norms for pre-school children. Let us consider other published developmental data for speech and language.

Gesell and Amatruda in *Development Diagnosis* include Language in their Behavior Inventory along with Motor, Adaptive, and Personal Social Behavior.

The Vineland Social Maturity Scale, (Edgar A. Doll) which measures (V) social competence by gathering information from an adult (usually the mother) in eight categories: (1) self-help—general, (2) self help—dressing, (3) self help—eating, (4) communication, (5) self-direction, (6) socialization, (7) locomotion, and (8) occupation. This scale includes 117 items and gives age periods from 0 to 25+.

The Verbal Language Development Scale by Merlin Mecham is an extension (VI) of the communication portion of the Vineland Social Maturity Scale. The parent or the teacher is the informant. Fifty items of communication are used. They are categorized as listening, speaking, reading and writing. The total score is converted to a language age equivalent with the use of a table presented in the manual.

The "Communicative Evaluation Chart from Infancy to Five Years" compiled by Ruth M. Anderson, Madeline Miles, and Patricia Matheny, from Children's Hospital, Denver, is a means by which one can gain an impression of a child's overall abilities or disabilities in languages and performance. Items on the left side of each page are based on the average child's capacity to gain and use language as a tool. They deal with the coordination of the speech musculature; development of hearing acuity and auditory perception; acquisition of the vowels and consonants; and growth of receptive and expressive language. Items on the right side of the page evaluate physical well being; normal growth and development; motor coordination; and beginning visual-motor-perceptual skills. It is hoped that by use of this chart, early detection of childhood communicative disabilities will result. Thus, early referrals to clinical services and early therapy can be offered to many more children.

In the evaluation of language, we must test the in-put and out-put channels. This has been designated by various terms, but let us use now receptive, inner and expressive language. Seeing and hearing are the main ways in which we learn.

Hearing testing depends upon the availability of equipment. We can test hearing with pure tone audiometry, proceeding from a screening test to a threshold test with air and bone conduction. Certainly every child that you suspect of a hearing loss should be referred for hearing testing *anytime* that a loss is suspected. Early testing can be done and should be done if there is any question.

Dr. Claude Hayes in a seminar this past summer co-sponsored by the Bureau for Handicapped Children and the University of Wisconsin stated that an audiologist should test these aspects of hearing for a complete evaluation: (1) sensitivity, (2) discrimination, (3) recognition, (4) understanding, (5) interpretation, (6) memory, (7) recall, and (8) appropriate motor response. As Dr. Hayes stated, "Hearing plays a part in speech therapy 'for as he hears, so will he speak'."

Audiometry is most crucial in differential diagnosis and Dr. Hayes believes that there are certain characteristics that differentiate the Deaf child (consistency), from the Aphasic (inconsistency), the Emotionally Disturbed (ignores sound) and the Mentally Retarded (not interested). Audiological evaluations can help to differentiate the major Handicap and to determine what the rehabilitation should be.

The *Development Test of Visual Perception* by Marianne Frostig in (VIII) collaboration with WeltyLefever and John Whittlesey, (1961) tests various aspects of vision. It contains five sub-tests.

Test I. *Eye-Motor Coordination* — a test of eye-hand coordination involving the drawing of continuous straight, curved, or angled lines between boundaries of various width, or from point to point without guide lines.

Test II. *Figure-Ground* — a test involving shifts in perception of figures against increasingly complex grounds. Intersecting and "hidden" geometric forms are used.

Test III. *Constancy of Shape* — a test involving the recognition of certain geometric figures presented in a variety of sizes, shadings, textures, and position in space, and their discrimination from similar geometric figures. Circles, squares, ellipses and parallelograms are used.

Test IV. *Position in Space* — a test involving the discrimination of reversals and rotations of figures presented in series. Schematic drawings representing common objects are used.

Test V. *Spatial Relationships* — a test involving the analysis of simple forms and patterns. These consist of lines of various lengths and angles which the child is required to copy, using dots as guide points.

This test is designed to measure certain operationally defined perceptual functions, and to pinpoint the age at which they normally develop. Children who deviate from the norm can be identified, and training procedures designed to correct the specific disabilities can be instituted. Dr. Frostig and David Horn have developed "The Frostig Program for the Development for Visual Perception." It contains step-by-step training from the simplest activities in discriminating body positions, through complex problems involving perception, identification, and creative solutions.

The Bender Gestalt test (copyright 1946) by Loretta Bender, M.D. has been used as a maturational test in visual motor Gestalt function in children. It is also used to explore retardation, regression, loss of function in organic brain defects in both adults and children, to explore personality deviations, especially where there is regressive phenomena. Gestalt function, according to Miss Bender, may be defined as that function of the integrated organism whereby it responds to a given constellation of stimuli as a whole. The response itself, being a constellation or pattern or gestalt. Integration occurs by differentiation. Figures 1 to 8 are given in sequence and sheets of plain white unlined paper are given. There is no time limit on the test and the figures need not be removed until they are reproduced.

Dr. Bender states that the evaluation of the test does not depend upon the form of the reproduced figures alone, but on their relationship to each other, to spatial background, to the temporal patterning and the clinical setting.

Dr. Elizabeth Koppitz used the Bender test in research and has written the text, "Bender Gestalt Test for Young Children," in which she has amplified on the relationship of the Bender Test to intelligence and school achievement; the Bender Test as a test for diagnosing brain injury; the Benter Test on mental retardation in young children; the Bender Test in emotional disturbances in young children. Scoring of the test for each of these areas is discussed fully in her book.

The Draw-A-Man Test (Goodenough) also gives us information regarding the child. Goodenough said, "the child draws what he knows, not what he sees." Children's drawings have form and have meaning. They move from the simple to the complex and language seems to be closely related to the child's ability to draw.

Children's Drawings as Measures of Intellectual Maturity, Dale Harris, 1963; discusses the implications of the Draw-A-Man Test, and other drawings.

The I.T.P.A. *(The Illinois Test of Psycholinguistic Abilities)* by McCarthy and Kirk: The authors, McCarthy and Kirk, describe their test as designed to assess a person's performance in nine different psycholinguistic abilities. To specify any one of these nine psycholinguistic abilities it is necessary to talk of it in terms of its 3 dimensions: LEVEL *(Representational* or *Automatic-sequential); PROCESS (Decoding* or *Encoding* or *Association);* CHANNEL *(Auditory-vocal* or *Visual-motor).*

I. All tests at the REPRESENTATION LEVEL asses some aspect of the person's ability to deal with meaningful symbols—

to understand the meaning of symbols (decoding)

to relate symbols on a meaningful basis (association)

to express meaningful ideas in symbols (encoding)

A. *Decoding tests: Decoding* is the ability to comprehend auditory and visual symbols.

1. *Auditory decoding* is the ability to comprehend the spoken word.
2. *Visual decoding* is the ability to comprehend pictures and written words.

B. (X) *Association tests:* Association is the ability to relate visual or auditory symbols (which stand for ideas) in a meaningful way.

3. *Auditory-vocal association* is the ability to relate spoken words in a meaningful way.
4. *Visual-motor association* is the ability to relate meaningful visual symbols.

C. *Encoding tests:* Encoding is the ability to put ideas into words or gestures.

5. *Vocal encoding* is the ability to express one's ideas in spoken words.
6. *Motor encoding* is the ability to express one's ideas in gestures.

II. All tests at THE AUTOMATIC-SEQUENTIAL LEVEL deal with the non-meaningful use of symbols, principally their long term retention and the short term memory of symbol sequences.

D. *Automatic tests:* Frequent use of a language and the redundancies of language lead to highly overlearned or *automatic habits* for handling its syntactical and inflectional aspects without conscious effort. We are so familiar with linguistic structure that we come to expect or to predict the grammatical structure of WHAT WILL BE SAID OR READ from what has already been heard or seen. In speaking or writing, these automatic habits permit one to give conscious attention to the contents of a message, while the words with which to express that message seem to come automatically.

7. *Auditory-vocal automatic* ability permits one to predict future linguistic events from past experience. It is called "automatic" because it is usually done without conscious effort.

E. *Sequencing tests:* Sequencing, as used here, is the ability to correctly reproduce a sequence of symbols; it is largely dependent upon visual and/or auditory memory.

8. *Auditory-vocal sequencing* is the ability to correctly repeat a sequence of symbols previously heard.
9. *Visual-motor sequencing* is the ability to correctly reproduce a sequence of symbols previously seen.

Dr. McCarthy, in discussing this test, reiterated that general language is the most important tool a child or adult has to work with. Communication must have a common symbol system and the systems must be the same. You must have the meanings in your mind or be able to fabricate the concept and the speaker must have something in his mind to communicate. He stated that factors which influence language learning include (1) age, (2) socio-economic class, (3) sex, (4) degree of intelligence, and (5) affective factors, such as (a) how do you feel? and (b) motivation. Much field testing of the I.T.P.A. has been done, and revisions are being made.

There are two other Language Tests I would like to mention. The Houston Test for Language Development (Part I and Part II) by Margaret Crabtree. Part I of the test established the language scale up to the age of three. Part II extends the language scale through the age of six. Dr. Crabtree writes in the manual for Part II that this test should be used in conjunction with information from a case history, an educational history, a speech evaluation, mental tests, an audiological study and medical reports.

The items tested include self-identity, vocabulary, body parts, gesture, auditory judgements, communicative behavior, temporal content, sytactical complexity, sentence length, prepositions, serial counting, object counting, repetition speech patterns, repetition melody patterns, geometric designs, drawing, verbalization while drawing, and telling about drawing.

Dr. Crabtree feels that the items that make the most unique contribution of this test are related to the spontaneous connected discourse. The choice of objects used in the test (the doll family) has made it possible to get more spontaneous reactions from the child with less adult participation. Again, the child's performance can be compared to normative data.

The Berry-Talbott Language Tests by Dr. Mildred Berry (copyright 1966) is the first in a series of exploratory tests of linguistic structure. This test of grammar and syntax is limited to the knowledge of linguistic morphology common to children 5 to 8 years old. It assesses: (1) the plural and two possessives of the noun, (2) the third person singular of the verb, (3) the progressive and past tense, and (4) the comparative and superlative of the adjective. (XI)

There are 27 pictures to present to the subject. He can read along or the material can be read to him. The material is being field tested. At present there is no normative data for various age levels, but Dr. Berry feels that an average 8 year old can go through the series of tests.

And now, what have we learned about the child? How does he measure up to the "normal"? What norms are applicable to this particular child at this particular point in time?

In our clinical judgement, what is the degree of the communication deviation? Is it a handicap? How does the child feel about it? What can he do to change the pattern of his speech?

Shall we refer him to another resource? (Example, to an otologist? or the psychologist? Shall we begin work with him in speech? Shall we confer further with his parents, his teacher?

All the testing we have done, gives us leads to some resolution of the child's problem.

Let's follow the leads.

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GROUP I

TECHNIQUES IN DIAGNOSIS AND APPRAISAL OF CHILDREN WITH COMMUNICATION PROBLEMS

Leader — Mr. David Mills

Recorder — Mrs. Linda Boles

Consultant — Dr. Robert Roach

As public school speech therapists we must educate administrators and the public as to what our job is and what our limitations are.

In depth observation can be made in schools over a period of time although we have less time with the child than the clinical therapist does.

Long range testing and observations can be made in public school speech therapy.

We need standardized tests to document what has been done in therapy and diagnoses and as common communication in referrals and for purposes of prognosis. We also felt that perhaps a battery of selected tests could be devised to use in public schools.

Teachers can give a brief case history to you at the school. We can refer the more severe cases. There are clinics in every major area of the state and private and public agencies can help.

We concluded with the feeling that conferences of this type are of great benefit to us as public school speech therapists.

GROUP II

TECHNIQUES IN DIAGNOSIS AND APPRAISAL OF CHILDREN WITH COMMUNICATION PROBLEMS

Leader — Mrs. Linnie Mae Brobston

Recorder — Mrs. Diana Bush

Consultant — Dr. "Buck" Ranney

These tests may be used to determine which children would profit from Speech Therapy.

Pure-tone Test may be used to determine slight loss or severe loss of hearing. Severe losses should be referred.

Test every child

Articulation test should be used to determine:

voice fluency
sound substitutions
sound omissions

Example:

The Look and Say method is one way to check for articulation problems.

Language development areas:

Peabody Picture Vocabulary Test
Goodenough's Draw-A-Man
Language elements of the Vineland Social Maturity Scale
Therapist Teacher's Observation

Among the things Mrs. Phair discussed which clinicians in Alabama are not using but should use are motor test and visual tests.

Psycholinguistic

Therapists are aware of but do not use ITPA and other psycholinguistic

The therapists agreed with Mrs. Phair that we need to know more about the total language of each child. More attention should be placed on the quality and grammar logic and structure rather than on articulation.

Problem Case Loads, and lack of training are not excuses for poor quality speech correction programs.

GROUP III

TECHNIQUES IN DIAGNOSIS AND APPRAISAL OF CHILDREN WITH COMMUNICATION PROBLEMS

Leader — Mrs. Alva K. Wolf

Recorder — Mrs. Donna Dunnam

Consultant — Dr. Jasper Harvey

The primary idea seemed to be: All of us need to be more thorough in our background information about *all* of the children on our schedule. Dr. Harvey brought out that we should teach in specifics—not just a stab in the dark!

The tests mentioned in our group were:

(1) the ITPA was felt to be very valuable and the Peabody Vocabulary Tests also.

Everyone was interested in the Van Riper Predictive tests and hope to have further information at a later date.

Our group enjoyed examining the materials Mrs. Phair left with us.

A recommendation was made that it would be advantageous if everyone on the administrative level could enroll in special education courses or receive courses during their college program.

With focus on the "whole" child we are reminded of the importance of faculty — speech therapist relationships!

Various positive suggestions were given such as:

a. home visitations
b. in-service training where possible
c. progress reports to parents and teachers
d. participating in faculty meetings, PTA and special school activities

GROUP IV

TECHNIQUES IN DIAGNOSIS AND APPRAISAL OF CHILDREN WITH COMMUNICATION PROBLEMS

Leader — Dr. Betty Webster
Recorder — Miss Elizabeth Queen
Consultant — Dr. William Center

1. Time be allotted for testing throughout the year.
2. Minimum number be abolished and that therapist be assigned to schools but with no specific number.

Discussed

1. Why we test
    a. Grouping
    b. Prognosis
    c. In order to communicate with other personnel
    d. Level at which to begin therapy with the child
2. Therapists need to understand
    a. Rationale for testing — test would depend on individual child
    b. Not looking for I.Q.'s but of child's ability in regard to speech
    c. Recognize limitations both in regard to testing and tests

GROUP V

TECHNIQUES IN DIAGNOSIS AND APPRAISAL OF CHILDREN WITH COMMUNICATION PROBLEMS

Leader — Miss Vivian Roe
Recorder — Mrs. Emily Cravey
Consultant — Dr. Gale Lambright

To what extent can public school therapists do complete testing?

Do we need to do all of this for each child?

Observations may give you some idea of which tests to use. Also it depends on what is available.

We may select some items from each test in so doing can facilitate getting pattern of which tests to use.

What are some things speech therapists would want to do to get some clues or indications as to which area to test? For instance, observation of muscular coordination, personality problems, relation of child to peers and general situation, social, classroom, lunchroom, etc., may not need to leave classroom to determine this. What would be different in the approach to adolescents from approach to smaller children? Terminology would be different and also relating work to total academic program would be different. We may give them sense of responsibility by asking if they have noticed the problem and did they know help was available.

How much diagnosis work should be done on the adolescents? Be careful not to put up barriers to recognizing problem; or if child has deviation in speech, that is not a problem don't make it one. On the other hand, a child may not have much of a problem, and adults in his environment may say he has problems. This calls for good parent counseling, stressing perhaps the importance of letting him grow out of it. One can't tell which ones will have emotional problems. We may find out that a problem that seemed simple is not easy to correct. If the teacher says speech is the problem, you should take him into therapy because sometimes teachers or parents may be excellent at identifying problems for clinicians. We do most of our own identification, but others may also identify some problems for us. We should take advantage of this resource. Also we should always follow-up with the teacher on how the diagnosis came out.

We should always stress for what we are looking. Divide paper into two parts. Show above a line the sounds he does correctly, below the line the sounds that he can't make, so parents and the child may see if he can do them. If the child can make sounds some of the time, but not all of the time we can also show them that this is analogous to the situation with other developmental skills. Things to do diagnostically:

1. Check general motor coordination
2. Personality problems
3. Case history, might secure one from parents if possible

It is suggested we add children to case load gradually so that we have some time for diagnostic work for ones we feel we need to test further.

We might let teachers decide as a group when to schedule children.

Suggest to the principal that he ask the teacher to check pupil for the therapist to see in May, as she has known children longer.

It won't put pressures on self to work from the first day with each child if you impress the tone of the relationships — what we do, and how we do it upon teachers, and perhaps parents.

If we use block system, we may be more flexible about taking some time to survey a new school the spring before.

It is suggested to keep Tuesday for schools worked with previously and Thursdays be kept for new schools you will be seeing. Does child make more progress if seen every day?

Motivation may drop if therapist sees children every day? Different therapists feel differently about this.

Degree of difficulty of problem may make the difference; or motivation may make difference. Predictive tests may find out if children are ready, predictive measures may be developed that will tell us whether or not this subjective factor is present. Use a variety of motivation methods.

We need to orient public school teacher to helping in cases in which they can be helpful. When we correct speech, we are teaching a new sound, we may explain to teacher and parents how to reinforce this.

CHANGING CONCEPTS IN COMMUNICATION PROBLEMS IN CHILDREN . . . IMPLICATION FOR THERAPY

Mrs. Gretchen Phair

I should like to discuss this under four main points: teacher aides, computers, the language emphasis, and the extension of the school year.

Much has been written in the general educational field within the last four years regarding the use of auxiliary school personnel. A statement by the National Commission on Teacher Education and Professional Standards (TEPS) published within this last year describes the kinds of jobs and responsibilities that auxiliary personnel might be able to take. Within the school framework, these types of paraprofessional tasks are suggested: clerical aides, library aides, housekeeping aides, non-instructional supervisors, instructional assistants, human relations skills, and specal talent utilization. This list, of course, is not complete but it does indicate some possibilities of using auxiliary personnel services and it highlights some of the jobs and levels of responsibility.

Our own state has been interested in this for the last several years and United States Senator Gaylord Nelson of Wisconsin introduced Legislation in the 90th Congress to establish a national teachers aide bill. This bill is to help solve the teacher shortage and to provide teachers with more time to perform instructional functions. The bill requested funding for training aides and for hiring aides. The training program would call for pre-service training, in-service training, and follow-up training.

Our Wisconsin State Superintendent, Mr. William Kahl, stated that the role of the teacher is changing and we will need teacher aides, lay assistants, technicians and para-professionals. Regarding certification and licensure, Mr. Kahl commented that the basic consideration is the protection of children by seeing that adequately trained personnel instruct the children. The certification and licensure process must be flexible to adapt to changing needs to promote rather than limit the role of the teachers. The need for certification is determined not by the title given the position or the job but the activities the position or job calls for. At present in Wisconsin we have three non-professional certification jobs which are licensed for the schools. These are (1) theme reader; (2) supervisor of study halls; and (3) assistant monitor. Any person hired by the school district must be of known good character and judgement. The need for certification by the state depends entirely upon the function the aide or helper is to perform. Guidelines suggested by Mr. Kahl include: (1) high school graduation; (2) the ability to communicate with good speech and writing; (3) high moral character; (4) personality characteristics, a degree of maturity and good health; and (5) skills pertinent to the duties.

At the present time in Wisconsin we do have a teacher aide pilot program in the Racine and Madison public schools. Hopefully, these pilot programs will be able to identify, define and develop the role of the teacher aide and set up some guidelines for pre-service and in-service training. Reports on the first semester of these two programs show that the feeling is that the teacher aides are very helpful and that they have been able to carry on the work suggested for them. The teachers have felt that teacher aides have been most helpful in small group or individual work, and least helpful when they took over a whole classroom.

A number of projects nationwide of training teacher aides and community helpers under the Office of Equal Opportunity were concerned with providing jobs for people in the disadvantaged areas. From the standpoint of professional approval, it seems that our first consideration should be the needs of the child and school.

One of the most interesting programs concerned the trainees for preschool and kindergarten aides. This particular program was done in the Ypsilanti, Michigan school in 1966. Its purpose was to prepare high school students for employment as preschool and kindergarten aides. I would like to go into detail on this training program since so much of the training relates to our profession as we are engaged in helping children who do not have good speech and language development. The young people were well selected. Personal qualities and character traits included appearance, relationship with others, and efficiency in work. Some of the basic training concerned understanding child behavior and discipline. The aides were taught how to observe the child, how the child was adjusting to school, and how they, as aides, might influence behavior. Influencing behavior (discipline) was discussed under the following topics: (1) explaining the reasons for behavior; (2) consulting the child; (3) offering alternatives; (4) controlling the environment; (5) isolation; (6) praise and reward; and (7) punishment.

Methods of helping the children included: Understanding child growth and development from the standpoints of development and differences. A chart of development for preschool children listing (A) Physical, (B) Social, (C) Emotional, and (D) Intellectual Abilities was discussed. The learning process was discussed under these topics: (1) acquiring skills, (2) the nature of the task, (3) factors that inhibit learning, (4) learning how to help the child, (5) help with motor skills, and (6) help with discrimination skills, particularly seeing and hearing. The aides were taught to help the child *to see* the difference in size, shape, color, number groups, and background and foreground in discrimination of pictures. They were taught how to listen *to hear* the sound, to hear the direction of the sound, and to tell the whole or parts of sound.

The aides were taught how to develop communication skills. This included informal and formal language instruction, and description of how children learn to talk. Simple, understandable language was used in this teaching. As an example — the stages of language development included; (1) crying, screaming, whimpering; (2) babbling and gurgling; (3) labeling by name; (4) then two word sentences; and (5) grammar with sentence structure; and (6) sentence patterns. The importance of the preschool years and the factors that affect language development were impressed upon the aides. These factors affecting language development included dependence upon adults, the practice of using words, receiving praise for the effort of using words, and errors that are acceptable because the child is young. The child never feels that he has failed. Children are encouraged in language development because language helps social behavior, helps to explain reasons, helps to provide information, helps the child to think and helps the child to read. Problems of listening were discussed, especially how to improve listening habits and the suggestion was made that you get set before you are ready to listen. The methods of encouraging language included large charts for vocabulary so that words could be added as they were learned, memory for words and events (a review day) and explaining relationships.

The aides in this program were also given help in developing cognitive skills. At level I (birth to age two) children learn how things feel, smell, sound, look, and taste and then they recognize these things. At level II (from two years to seven years) likenesses and differences, remembering, developing discrimination skills, and developing concepts of time and concepts of number. Whether or not all of these concepts can be put into practice with the limited training in their program is still to be proved, but it does point up the fact that preschool language training may be a necessary preventive measure and thus an influence on our profession.

At the present time the Bureau for Handicapped Children in Wisconsin is sponsoring a special aide project with the City of Milwaukee under the direction of our research director, John Cook. The plan of this particular research was to see the efficiency of the use of teacher aides with larger classes of mentally retarded children.

At a recent three day session for the teacher aides and the teachers, Dr. Kenneth Blessing in the keynote speech gave these purposes of the research: (1) the manpower needs in special education, (2) the improvement of instruction, and (3) to delineate the role of the Bureau for Handicapped Children (a state agency) in research.

Reports at the end of the first semester suggested: (1) there was good teacher reaction, (2) several of the teacher aides are planning to go into special education, (3) the administrators wish to keep the aides, and (4) the filmed sequences showing effective use of the aides could be used in teaching projects. The role and function of the aides must be delineated.

This project has been extended and will continue in order to give us more information regarding the salient points above-mentioned. Dr. Al Solforenko, speaking at this meeting, suggested that the certification of the teachers aides must be studied. He stated that the needs of the children are paramount. One of the main contributions of an aide is to be so trained as to observe the behavior of the child and trained to report back to the teacher the observation of the behavior of the child.

And now to our field of speech and hearing. In early September at a meeting in Washington, sponsored by the Office of Education and called by ASHA, discussion was held regarding the pertinence of supportive personnel to the field of speech and hearing in a school setting. James Gallagher, the new chief of the Bureau of Education of the Handicapped in the U. S. Office of Education, was the first speaker. He spoke of the manpower needs, particularly regarding handicapped children. As examples, in the field of M.R. 70,000 teachers are trained and five times that many are needed. Reports from *ASHA* showed that there are 16,000 trained speech and hearing personnel in the United States and there is need for 40,000. He discussed: (1) the medical professions' use of ancillary personnel, (2) school psychologists are finding that they can use supportive personnel, (3) job analysis is necessary in order to know what the major task is each hour of the day, (4) the role of women, a resource on a part-time basis, (5) the greater professional accomplishments with auxiliary personnel, (6) how the role of professional person would change,, (7) what new supervisory responsibilities the professional would have, and (8) supportive personnel in relation to the multiply handicapped.

Professor Leo Goldman, in the field of guidance, talking on help for the professional in his field, stated that the use of the term "helper" was a good one because it had no bad emotional connotation. In projecting into the future he felt that machines will be able to administer and score tests and give feedback to the person being tested. He felt that the computers can process for guidance, but that human helpers were necessary in some areas. In the use of human helpers, he spoke of social work where helpers could collect data for the welfare roles; in pediatrics where the assistant could take the history, and weigh and measure children and give out information; and Bruner's research at Penn State in which the older students could help the younger students. They found in the Rochester, New York schools that the school clerks were helping children with things that ordinarily the counselors did. The jobs that the helpers could do have to be listed and prepared by the guidance personnel.

A panel consisting of Dr. Davies from Education, Miss Ullrich from Nursing, and Miss Lindoff from Physical Therapy, explained the ways in which auxiliary personnel are used in their professions.

Dr. Michael Marge, now Director of Planning in the Office of Education, discussed "Our Crises". He spoke of the need for licensure for people working as aides in the field. He spoke about teaching machines and how they could be used, and he stressed the need for research in the area of *prevention* of speech and hearing disorders.

The objectives of this institute were to acquaint the participants with the utilization of supportive personnel by other professions, to focus attention on both the problems and the potential advantages of using supportive personnel in the school speech and hearing programs, and to discuss the long range effects which the use of supportive personnel might have on the manpower shortage, on the training and responsibilities of speech pathologists and audiologists and on the financial support for the speech and hearing services in the school.

Guidelines for discussion of the institute attendees were posed as questions. If supportive personnel were trained, and used in school speech and hearing programs, what effect would this have on the manpower shortage? the American Speech and Hearing Association? the professional status of certified speech pathologists and audiologists? the public image of the profession? the extent and quality of services? the service to urban, rural, economically depressed, and less populous geographic areas? the legal and financial regulations of the state? the relationship of speech and hearing professions to other professions? and the impact on educational and training programs?

Dr. John V. Irwin, President-Elect of ASHA, prepared a paper on supportive personnel in speech pathology and audiology which was presented to the participants of this institute. It has been published in the September issue of *ASHA* and should be read by all members of our profession. In this paper. Dr. Irwin also points out the manpower need. Approximately 5,000 people more are needed to fill the immediate jobs. He points up this need *in services* where 40 thousand professionally trained individuals are needed. He points up the need *in training* where we need more staff in the colleges and universities, 88% of our training programs needing additional faculty. He points up this need *in research* since only 2% of our professionally active members of ASHA work in the area of research.

Dr. Irwin discusses the possible solutions to the personnel shortage. In addition to recruitment programs and comprehensive evaluations, he suggested other solutions such as funding, programming, case selection, and evaluation, training, and supportive personnel. He discusses the many problems within this field of supportive personnel and suggests that all of us face the problem with a view to doing something about it.

There were two research projects reported upon at this meeting: A Pilot Project — "Speech Aide Program in the Coffeyville School" — reported by Nicholas Bankson, State Supervisor of Speech Correction — Kansas; and "A Statewide Audiometric Training Program" in Illinois — submitted by Raymond Bernero, Illinois Department of Public Health.

The report on this conference should be available soon. It is being edited by Dr. John Moncur.

A questionnaire on teacher aides in speech correction was conducted for the Bureau for Handicapped Children, Department of Public Instruction, Wisconsin, by Richard Jentoft, an administrative intern. This survey was to ascertain whether or not there was a need for such personnel in speech correction. A questionnaire was sent to 50 speech clinicians working in summer speech programs in 1967. 82% of the questionnaires were returned. Of those returned:

60.9% felt such aides could be used;
96% felt there was a need for study or research on the use of aides in speech correction.

The duties of aides as suggested by the clinicians were primarily clerical or secretarial. In direct therapy the aides possibly would be of benefit in drill work, taping on the tape recorder, and carry-over work. Regarding qualifications of the aides — an understanding of children was paramount. A majority of clinicians felt they could train aides. The writer concludes that further research on guidelines for training and utilization of aides is necessary.

The use of supportive personnel in the aspects of case-finding and prevention were discussed at a Bi-regional Conference on Speech and Hearing in May, 1967, at Columbus, Ohio, sponsored by Children's Bureau, Department of Health, Education & Welfare. Supportive personnel (particulary parents have been used in hearing conservation programs for many years. Wisconsin has followed this practice for over 20 years.

Computers

The use of terms in any field becomes a part of the jargon used by that profession. In order for us to be sure that we are communicating with other professional groups we need some standardization of terminology. Our profession has sought for many years a name that would satisfy all of us *within* the profession yet would have meaning for people *outside* the profession. We have moved from speech correctionist to speech therapist and are attempting to move to speech clinician.

With the increased use of computers we must carefully assess our field for understandable definitions. At the present time, the U.S. Office of Education has a preliminary edition of the cooperative project for standardization of terminology in instructional programs of local and state school systems. This handbook (No. VII), in its third draft, has to do with state educational records and reports. It is called, "Standard Terminology for Instruction in Local and State School Systems" and it is an analysis of instructional content, resource, and processes. The American Speech and Hearing Association, as an organization, was consulted in the preparation of this draft. Other professional groups have also worked with the U.S. Office of Education. The handbook is a guide to local and state school systems for items of information used in keeping records and making reports about curriculum and instruction. Speech Pathology and Audiology Services are included as services supporting instruction. After field testing and general usage by local and state school systems, this material may be of great import nationally.

Perhaps some of you are familiar with Rehabilitation Codes, Inc. The Rehabilitation Codes are a record of the person who needs help with problems he cannot solve alone. The focus of the record is the *person* rather than the problems, agency, professions, or services. The Codes grew out of the expressed needs of professional people for definitions and terms which could be agreed upon and used consistently to exchange information about the people they serve. Research on record keeping throughout the country showed how inadequate and inconsistent the current methods of collecting and recording information are. Information often was couched in a language which was too technical for easy communication between professional personnel, trained in different disciplines. All of these factors have impeded and perhaps even negated the rehabilitation process.

Professional people recognized that some way was needed to describe the person's response to his problems and to their services without using the customary jargon of each professional discipline. If full and pertinent information could be gathered, easily handled record forms must be designed. If this were done, perhaps some improvement in the standards of service could be effected. This task is being attempted by Rehabilitation Codes. A selective record keeping system was developed and can be directly transferable to punch card or tape storage processes. The text provides a common language to record information about the person which is significant to the rehabilitation process. Through constant study in the last ten years, the Codes substituted dictionary English for jargon, not only in the descriptions of the records, but also in the classification of impairment. The aim has been to refer to the individual not as the patient, but as a person. Rehabilitation builds upon the person's resources. The Codes describe the person as a whole, living in the context of his family and community group.

Basic to discussion of the Codes are the definitions of (1) Impairment — which is any deviation from normal development, structure, organization or function of the whole, or any of the faculties, senses, systems, organs, or members; (2) Disability — which is any limitation of function experienced by the impaired person compared with the unimpaired persons of his age and sex; and (3) Handicap—which is the disadvantage imposed by impairment and/or disability upon a specific person within his cultural context.

Any impaired person is not necessarily disabled or handicapped by the impairment, but, he may be either disabled or handicapped or both.

Rehabilitation is the concept in process of a disabled or handicapped persons optimal achievement of self-realization. This may be through his efforts alone or with assistance from his family or community. His rehabilitation potential lies in the interplay of his problems and the resources available to solve them.

All of the possible functions of the human being are categorized in the Codes. The ones we would be concerned with professionally are: the function of awareness, of hearing function, of kinesthetic function, proprioceptive function, attention, sensoral selectivity, memory function, orientation function, body image, imitative expression, language function, thinking processes, speech function, voice function, and personality function.

In reviewing just the impairment of speech function, categories used are:

540—Absence of speech function
541—Impairment of articulation
542—Impairment of fluency
543—Impairment of stress

Categories used for impairment of rate are:

544—Inappropriately fast
545—Inappropriately slow
546—Inappropriately varied
547—Impairment of concomitant audible behavior
548—Impairment of concomitant visible behavior
549—Impairment of Speech Function NEC/NOS

(NEC/NOS—not elsewhere covered/not otherwise specified)

The impairment of voice function and language function are likewise categorized.

In addition to tallying information in diagnosing cases, computers are being used as teaching machines. Dr. Garret at New Mexico University has been one of those in our field who has pioneered in this effort and his material is now available. Some of you are perhaps more familiar with other areas of programmed materials that are fitting into the field of speech and language.

Let us now look at the emphasis placed on language. Why is there such an emphasis? I think two reasons.

One, our failure with certain children or cases. By 'our', I'm speaking collectively of speech clinicians, teachers of the deaf, hearing conservationists, remedial reading teachers, and other remedial teachers.

No matter how many grade levels or categories we set up to fit children in, there are always some children who don't quite fit. The teachers of the deaf have said that they have children who are not "truly deaf" but have other learning problems. The teachers of the mentally retarded likewise have children whose learning problems cannot be explained only in terms of a slower rate of development. Speech clinicians have used a term "delayed speech and language" when their cases could not be identified, as articulation, stuttering, or voice.

Two, our recent professional realization that certain cultural groups have not developed language that meets the standards set up for entrance into school, or that we have concluded is "normal" for most children at a given age.

To remediate or help prepare the "culturally disadvantaged" for school we have started formal education earlier in "Operation Headstart". We are giving experiences earlier so that language has been improved. This has enabled us to study younger children. The teachers of the deaf have said that deaf children need early emphasis on language and so in many states younger children are allowed to come to school for some training in language. In our state a deaf child as young as two years of age can be given help by the teacher of the deaf in any Day School for the Deaf.

In the profession of speech and hearing, early diagnosis and differential diagnosis have interested many people. It would be difficult to name all of the people who have made contributions, but you are undoubtedly reviewing many of these names in your mind.

Yesterday we spoke of the differential diagnosis as sorting out those children whose problems are *primarily* mental retardation, deafness, emotional disturbance, or special learning disorders from those who are multiply handicapped. In our schools we are now including special classes and/or special tutoring for these children. We have gathered together (as a team) information regarding the psychological, medical, social and emotional, and educational aspects of the child's development and have pooled our information to plan for the needs of the child.

The recently published book, "Learning Disabilities, Educational Principals and Practices" by Doris Johnson and Helmer Myklebust deals with children who have a psychoneurological deficit. Their definition presumes that there is adequate motor ability, average intelligence, adequate hearing and vision, adequate emotional adjustment, *together with* a deficiency in learning.

Testing determines the integrity limits for hearing, for vision, for intellectual functioning, for motor abilities, and for the personality or emotional adjustment of the child. The deficit in learning may be non-verbal or verbal and so a learning quotient is established to differentiate. The detriment in learning may be receptive, integrative, or expressive acts. The measurement of the deficit and comparing it to normative data and planning for the child are included in the book.

Clinical teaching is emphasized by the authors of this book. The teacher is aware of the child's disability, of his strengths and weaknesses, and she does not assume that the same methodologies apply to all children. The teacher must be aware of both the psychology and neurology of learning, and her efforts are to bring about a balance between the child's tolerance levels and the stimulation provided. She considers the problem in multi-dimensional, not in unitary terms, and recognizes the need for controlling certain behavioral variables while activating or manipulating others. Quoting, "The child is viewed not only in terms of his learning disability but through other facets of behavior; that is, his social maturity, his emotional adjustment, his acceptance of and by the other children, his neighborhood, his friendships. Clinical teaching does not stress academic success *alone*. The pervasiveness of the problem, even those whose potential for learning remains above average, is kept clearly in mind. This approach is broad, inclusive, and dynamic. Only an approach of this type can be expected to meet the urgent challenge presented by this group of handicapped children." The program is individualized for each child or each group of children. The teacher recognizes that her approach depends on and involves *direct observation* as a patient, that success can be achieved by applying objective methods to the description, evaluation, and modification of human behavior.

The particular disorders included in this book are: disorders of auditory language, disorders of expressive language, disorders of reading, disorders of the written language, disorders of arithmetic, and non-verbal disorders of language.

In Wisconsin we have been developing some special classes for children with language disabilities. We have a number of Special Learning Disorders Classes, in the City of Milwaukee and several Special

Language Classes in the City of Madison. We have itinerant teachers for language problems, both in Madison, Milwaukee, and Wauwatosa. All of the speech clinicians have been made more and more aware of their responsibilities to the child who is truly handicapped by language function.

A program in Language (if you will) is presented in the Peabody kits for language development. They have been used in many Operation Headstart. They have also been used remedially by many educators and speech clinicians. Careful use of this material can be of benefit.

We have mentioned the extension downward in formal schooling in the training of children in projects such as Headstart. We mentioned also the possibilities of children, such as those who are deaf, having school experiences earlier than the traditional kindergarten in Wisconsin. In addition, we have noted a large increase in summer programs for the general school population but particularly a large increase in summer programs for speech and language. Four years ago in our state we had four summer speech programs. The next year we had seven. Last year there were 21 and this year 74 programs. With the extension of the school year into the summer and the extension of the school program to preschoolers, we are giving more service and better service to children.

Caution in our field is also necessary. In the JSHD (August 1966) in *Forum* — Dr. Charles Van Riper cautions us to learn from our failures as well as our successes.

Dr. Van Riper's philosophy is an interesting one. He says this: "I set my own personal goals in terms of maxima and minima and help my cases do the same, trying to formulate them so that the maximum can be attained occasionally while almost certainly the minimum goal can be assured. I found that sub-goals should be sequenced, if final goals are to be achieved they must be revised in the cold, hard light of confronted performance. None always hits the bullseye every time; especially when the human target is dimly lit, the clinicians bow imperfect, and the arrow crooked. Yet, we must shoot and keep on shooting better."

Dr. Philip Rosenberg from Tampa University School of Medicine cautions us on mis-diagnosing of children with auditory problems. He states, "A large number of diagnostic entities have become popular in recent years. These refer to auditory impairments involving the central rather than the peripheral auditory pathways. It is the feeling of the author that these labels are used much too frequently and that many patients with peripheral deafness are being mis-diagnosed with subsequent problems in auditory rehabilitation. A plea is made for the rigorous use of acceptable, classical, methods of auditory testing as well as the introduction of newer methodsof examining the auditory system. Early diagnosis is unquestionably of great value in the total rehabilitation of the accoustically handicapped child. Incorrect diagnosis, however, results in a needless waste of valuable years of training."

The four points emphasized today are not truly research topics, but they are trends in our field that bear watching. We should constantly be evaluating objectively whether or not we are serving best the children who are handicapped in communication.

All speech clinicians will not agree upon the issues in our field which are important today. I want to leave with you my thoughts regarding these four trends which I believe are important.

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GROUP I

CHANGING CONCEPTS ON COMMUNICATION PROBLEMS IN CHILDREN . . . IMPLICATIONS FOR THERAPY

Leader — Mrs. Mary Moore
Recorder — Mrs. Gibb Couch
Consultant — Dr. Jasper Harvey

Alabama Public School Speech and Hearing Therapy programs need whatever help available to carry out a program which will be most effective with the greatest number of children possible.

Supportive personnel would be effective and helpful performing such mechanical tasks as operating visual and auditory aid equipment, performing clerical duties, assisting pupils as they perform drill work preparing certain special teaching aids and administering hearing and articulation screening tests.

An extensive "time and motion" study to determine *exactly* what clinicians do would be necessary before deciding exactly what assistants *could* do. A training program designed to prepare supportive personnel could then be devised and implemental inthe best possible way. A program to train the professional persons as to how they might most effectively use this assistant also seems indicated.

Such "aids" would necessarily need to possess a "feeling" for children, an acceptance of a handicap or impairment as well as initiative and a sense of humor.

The training of such helpers or assistants need not pose a threat to the Speech and Hearing Profession if the members of the profession assume the responsibility of deciding what the training and responsibilities of these persons should be. It might well be used as a recruiting device for our profession.

There is one "sacred spot" in this profession. That is where the child and therapist meet and the therapist "knows when the right time has come to do the "right thing." This kind of responsibility cannot and should never be placed in the hands of a person not fully trained by Speech and Hearing Profession.

GROUP II

CHANGING CONCEPTS ON COMMUNICATION PROBLEMS IN CHILDREN . . . IMPLICATIONS FOR THERAPY

Leader — Dr. Laura Wright
Recorder — Mrs. Judy Copeland
Consultant — Dr. William Center

We could use aids or volunteers to help with:

1. speech and language stimulation.
2. play therapy.
3. preparation of materials, record keeping, typing, etc.
4. observation and carry over.
5. sense training.
6. remind children to come to therapy.
7. mass screening.
8. auditory training techniques.
9. leave more time for therapist to work with children individually.

GROUP III

CHANGING CONCEPTS ON COMMUNICATION PROBLEMS IN CHILDREN . . . IMPLICATIONS FOR THERAPY

Leader — Mrs. Lucille Grove
Recorder—Miss Becky Henderson
Consultant — Dr. "Buck" Ranney

I Requirements for aids
    High school diploma
        1 year training as an aid

II Uses of Aids
    1. as reinforcement of therapy after the therapist has gone to another school

III Needs of program
    1. Summer therapy program
    2. Computer programs with functional articulation problems
    3. Use of close circuit television and machines
    4. Use educational television
    5. Teacher involvement in providing stimulation through the phonetic program

Several thought aids were impractical in a school setting and detracted from the profession.

GROUP IV

CHANGING CONCEPTS ON COMMUNICATION PROBLEMS IN CHILDREN . . . IMPLICATIONS FOR THERAPY

Leader — Dr. Eugene Cooper
Recorder—Mrs. Norma W. Walton
Consultant — Dr. Gale Lambright

I. Supportative Aids

The group decided that aids could definitely be used for the following purposes:

- a. clerical work
- b. operating tape recorders
- c. housekeeping tasks
- d. operating language masters

A. Training of Aids

1. minimum of a high school diploma
2. aids must be taught to observe and report these observations to the therapist
3. the aids role must be clearly defined by the therapist so as to avoid conflict of roles

It was suggested that perhaps core curriculum centers could be established for training aids. Centers with intensive training similar to the ones used in The Head Start Program.

The discussion then moved to:

II. Language Development Problems

All speech work carries over to language. Speech is a part of the language art. One cannot separate sounds from language. We as a group were interested in this question: Have we as speech therapists been trained adequately for language training (i.e.) Have we had the proper courses to prepare us to teach our children language. The consensus of the group was that we have had language training in some course, although it may not have been called language training, as such.

GROUP V

CHANGING CONCEPTS ON COMMUNICATION PROBLEMS IN CHILDREN . . . IMPLICATIONS FOR THERAPY

Leader — Dr. Francis Griffith
Recorder — Dr. Ronald Evelsizer
Consultant — Dr. Robert E. Roach

A. Teaching Aides — basic questions underlying their use.

1. What is a logical compromise between efficient functioning and quantity production in therapy?
2. What is to be the role of supportive personnel?
    a. Continue small group work while the therapists pulls out children individually
    b. Utilization of specific people with particular skills as ancillary personnel
3. What activities and responsibilities are we as therapists willing to give up to the supportive personnel?
4. Will the therapist find herself in a position similar to that of the classroom teacher when therapy programs were new? That is, will she be threatened by the introduction of new service personnel?

B. Specialized terminology or jargon used by therapists

1. Is this a status symbol?
2. What does it do to communication?
3. Is this a means of denying our own shortcomings, a reluctance to admit that we do not have all the answers?

C. Therapists need to "accentuate the positive" when discussing or reporting cases and avoid constant reference only to the problem cases.

D. Reporting

1. Case reports may be one means of educating others to the role and work of the therapist.
2. Report writing helps the therapist review and re-evaluate her position and method of functioning.
3. Recording actual behavior, responses, methods used, may be more effective than the usual "report" system.

THE ROLE OF A PUBLIC SCHOOL SPEECH CORRECTIONIST

Miss Martha Black

The preparation of the local teachers and the public for the establishment of a speech correction service is an important activity and, if carefully done, will do much to insure the success of the program. Hopefully, a good administrator first gives his staff an opportunity to know what a speech program is and what it can be expected to accomplish in their schools. This can be done in various ways. A speaker, perhaps a therapist from a nearby district or from a university staff, may be asked to talk at a teachers' meeting. Or a committee of interested teachers may be given an opportunity to visit a good program and report what they have learned. The cooperation of outside local agencies, such as the health service, nurses, doctors, social workers, nursery school people, or any others, may be asked to report the names of children who appear to be developing speech too slowly. Of course, teachers can be asked to submit the names of children whose speech is below average. This in no way is a substitute for a survey by a trained person but it does help stimulate interest. The superintendent should give the proposed plan some publicity among the lay public. I do not know your law, but undoubtedly your school board first of all must give its consent for the establishment of a program. Then through a newspaper article, over TV or radio, and in public meetings such as P.T.A. groups, mothers' clubs, etc., some information should be furnished the public.

Now let us consider the responsibilities of a correctionist going into a new community. First is a job of interpretation. If the administration does not arrange it, you should seek opportunities to talk at building meetings, P.T.A., Clubs, noon luncheon groups, etc. Explain your program briefly and in non-technical terms. Don't promise the moon, but assure them that most children can attain normal acceptable speech. A new program needs publicity and you should take or make opportunities to give it.

If you go into an established program, learn all you can about the preceding service, records, equipment, etc. Use what you can and regardless of what you may think, voice no criticism.

An old correctionist going back to a program for the second, third or tenth year must continue the selling and interpretation of the service. There will always be new teachers who know nothing about speech correction as well as old teachers with new problems. Then, too, there are new parents each year. And, hopefully, you are a new person each year. You have grown; you have been to summer school; you have read a stimulating book; and you have had some time to rest and to bring a more mature as well as a refreshed personality to the work each fall. We regard diagnoses as a continuous process; so is the interpretation of our professional responsibilities and our recognition and utilization of the opportunities to meet our obligations.

Make plans for getting the absent ones at a later date. Also plan a card containing the name of a late enrollee to be sent routinely to the speech office. These late-comers will have their speech tested when you next visit the school.

If you are going to give service, you must have a room in which to operate. How big? We once talked about an office-like room that would accommodate three or four children, but now we are not so sure that is the most efficient size. We are thinking of two new concepts. One is the fact that in the foreseeable future there is not going to be enough trained people to meet the demands of the public. When I read of this National Teachers Force suggesting that any person who has a bachelor's degree in anything whatsoever may go out to teach the underprivileged — a most difficult task even for one trained in psychology and education — I grow fearful for what Big Brother, forced by public demand, may do to our profession. I think, therefore, we should give serious consideration to utilizing our talents to their fullest capacity.

Second, we now have available many machines and gadgets that, when intelligently used, can give us opportunities to serve greater numbers of children. To do this we need space, *and space is easier to come by than is trained personnel.* And another point: many people are beginning to think we should do more to bring the whole child, his arms, his legs, his whole being, into the speech act. Maybe there should be less of the across-the-table teaching and more of getting children into action as they talk. Again, we need space — not a room big enough to be converted into a classroom, because one that size is soon lost by the speech program, but one big enough to allow some moving around. Then, too, we are recognizing the value of having cubicles or booths where individual practice may be carried on. This is particularly true in work with older students. Rooms with one way windows make it possible to observe practice work in a couple of rooms simultaneously. Let's dream for a minute about what these suites might look like. Take a high school suite. First, there should be a recreation room. If all special services — nurse, psychologist, counselor, etc., are located in one area, then one reception room, with possibly a secretary in charge, can serve all. In the speech suite a small office for desk, telephone and files, several books. Then one fairly large room where group work (I think of 8 to 15 students) may be conducted. Then two or more small rooms where as many as two or three students might work together. These rooms should be equipped with one way vision and sound treatment, so the correctionist can always see into it and can tune in at will. In addition there should be a series of small booths where individuals may practice, using tapes, records, cards. There should be mirrors in all rooms and, of course, good lighting and ventilation. All should be sound-treated so speech in one does not disturb work in other areas. One room should be quite soundproof. Hearing may be tested here and practice that might involve loud voices or even shouting could be conducted. How many students might be served simultaneously? I'm not certain. The types of handicaps, the types of students, and possibly most important of all the belief, the preparation and the abilities of the correctionist are all factors.

Our grade school rooms possibly should be a slightly modified plan. How young can children be when given a degree of independence in practice, I'm not certain. I do know the Lake County experiment on utilizing vision to greater extent than most of us do found, after starting it in high school, that youngsters as young as second graders, and in a few instances first graders, could learn to work independently, and what's more, they liked it.

Basic furniture is what we have always wanted; namely, chairs and tables that are suitable for the children using them; shelves and cupboards for books, equipment and supplies; bulletin boards and chalk boards, locked files, a desk for teacher, telephone and a couple of comfortable adult chairs; attractive decoration and heat that can be regulated.

Not all of us are going to be working in a spot such as I've talked about, but all of us can start making plans, educating administrators and have plans ready to present when there is any opportunity for new buildings or the remodeling of older ones. Remember, these are the days of federal aid and of attention being focused on schools. Be prepared to do your bit to forward speech service.

Screening is naturally one of the first jobs. In a new program every child should have his speech checked, that is every child within a group of the size estimated to give a speech load. How big is such a group? 1000 to 1200 youngsters. If there are more children in the system, have the administrator select the schools or the grades to be served. You might look over the situation and make recommendations to the administrator. If there must be an elimination of some of the schools, first take out the schools which have poor facilities — no room — then consider location. If some have to be eliminated, consider those that are difficult to reach. Another criteria might be the attitude of the principal. The administrator would be the judge of this. Make the fact clear to all concerned that one therapist can serve no more than say 75 to 100 students at any given time. More therapists are needed. Service spread too thin destroys itself.

How do you screen? There are various plans. A quick overall test, followed by a detailed examination of suspected cases, is the general plan. Careful planning and organization will do the job efficiently. A plan I like is to have the therapist seated just outside the classroom door, if the corridor is quiet, or at the back of the room with possibly a screen around her. Have a table and a chair comfortable for the child, and good light. Then have cards that will elicit the wanted response. Also a paragraph to be read by older children. Then, too, have a few toys, little animals, sometimes a clown will get speech from a child who refuses to talk to an adult. However, keep the toys out of sight when they are not being used. Avoid distraction. Have the teacher introduce you, or do it yourself. Make your list of names in the order in which the children are seated. Have the teacher send the youngsters in that order. Recheck by asking for the name when the child comes to you. As one comes in, the one seated behind him is discovered, check the name for retesting. Every child enrolled is checked as either O.K., recheck, or absent. No time will be lost between cases. Work along quickly.

After you have surveyed all of the 1000 or 1200 youngsters, you plan the rechecks. You may use the same set-up but possibly it will be wiser to have the youngsters come to the speech room for this diagnostic test. In all likelihood you'll have to call for the young children and escort them to the speech room. The older ones may notify the next one wanted. You may or may not want to give the audiometric test at this time. Some people believe it is wise to wait a few weeks and let the children — particularly the younger ones — get better acquainted with you and you'll get better responses. Now you have finished the diagnostic tests — and the big job of case selection is next. Stack your diagnostic sheets from one school according to types of defects. Select the cases to be served, taking some from each type of defect. Now stack them according to grades. Then try to group them. Which cases can work well together? Make a waiting list. Now talk with the building principal about the time schedule. Work around recesses, reading periods, and any other very important claim on the children's time. After you have the principal's suggestions, talk with each teacher. There will have to be some changes. You may put some on the waiting list and take off others. There will have to be some give on your part as well as that of the teacher. You may have to put some children from different grades together. Now you have a tentative schedule. Put it in the principal's office and give each teacher a copy of the one for her children. She may post it, so don't put the diagnosis on it. Give her that on a separate sheet for each child, to be kept in her file.

On your waiting list will be those who need some type of service before speech can begin. Usually this will be medical. Here is where you work with the nurse. There may be something to be done by the social worker or the psychologist and you contact them.

Your schedules will be changing constantly. Some names will be taken from the waiting list to take the places of dismissed students. You'll find some groupings not workable and changes will have to be made. Changes in classroom activities may cause a change in the speech schedule. Always date your schedules and keep a copy in the principal's office. And *keep on schedule*. Most vital for the success of your program is that your schedule is posted and that you follow it.

Records and reports are most essential in an efficient program. Records must be detailed enough to give pertinent information and brief enough to make their keeping possible in the short time in which you must operate. Cards 6" x 4" may take care of the less complicated cases. Personal data, age, address, original diagnosis, dates of therapy, brief notes on progress, dismissal date and reason. However, cases involving more detailed study should have individual folders — personal data, health history, educational history, family situation, reports from parents, teachers, your own reaction, psychological tests, etc. Get all you can from existing records. Don't duplicate, but examine all with a critical eye. If you think it might not be correct, get fresh information. You want notes on day to day activity. Learn to work with a pencil in your hand and jot down ideas as they pop up. These sheets may be lesson plans and need not be kept beyond the year or semester or month, at which time you transfer information to cards or folders. *Time forces us to keep brief records* but *never sacrifice utility to dispatch.*

We have certain reports to make to our superiors. The policies of the school system and the state to a measure dictate these. We have mentioned time schedules. The building principal should know the names of students getting speech service. He may want a diagnosis. Progress reports should be given periodically, possibly twice a year on cases you hold that long and certainly reasons for dismissal on those discharged earlier. The superintendent will want statistical reports. Possibly these should be divided into types of defects. Maybe they will be required once a year, maybe oftener. But learn what the policies are and be prepared.

In addition, you will want to make recommendations. Supplies needed, (have correct names and addresses) building needs and reasons, changes in policies suggested and reasons. Unless an emergency occurs, these should be given the superintendent at designated times — end of semester or year.

Report to teacher. Much will be done by conferences, but always summarize your conference in a written report. Brief and have it contain a positive suggestion. Always give something.

Reports to parents. Your first meeting with parents may be at a P.T.A. or Mothers' Club, or you may invite in all the parents of the children you work with for a general discussion of speech problems and what we hope to do. Make these talks simple, non-technical, reassuring and brief. When you want to talk specifics and get down to brass tacks, have individual conferences. Don't schedule these on P.T.A. night. Too many ears around. Give the parent a definite time to come to school or to phone you. Discourage home phone calls. Your landlady or apartment mate should not be in on these private conversations. And besides, your evenings are your own. Don't be a correctionist all day and all night. When a parent calls, tell him politely that your case record is at school and if he'll call such and such a number at such a time, you'll be glad to discuss the problem.

Home visits are important, particularly for you. In no other way can you get the feel of the home situation. Make an appointment so mother will not be embarrassed. Don't go only when there is a disagreeable problem. Don't go only to the home which on the surface at least appears to be less than adequate. Any home may have a severe problem. If you have an unpleasant matter to discuss, such as special placement for a very slow learning child, or a serious behavior problem, try to get the parent to come to the school. The atmosphere of the school lends weight and professional dignity to you. When located at your desk, you are less of a friendly visitor and more of a professional person whose judgment is founded on a wide educational background.

In-Service Training —

These are the days of adult education; of continuous education. And certainly in a profession that is growing and acquiring new knowledge as fast as ours is, we need to be constantly studying or we'll soon be far behind. How can we keep abreast of the current changes? Time! The essence of all things. How can we best employ our time? One way is to be part of a team or group that has for its objectives the improvement of speech therapy. Most of us are rather isolated in our communities. We have few people with whom we can discuss professional problems. In Illinois we have found that area group meetings help. An area—a geographical unit within which it is fairly convenient for speech correctionists to get together occasionally form a little association. Usually it meets four or five times a year. Problems of current concern are discussed. Sometimes it may be an exchange of ideas for therapy; sometimes reports on new books or articles; sometimes reports on meetings—(those who go to A.S.H.A. report)—sometimes a speaker; sometimes clinical demonstrations, etc.

Another means is a statewide newsletter. We began with a Round Robin mimeographed. Now we print a Newsletter. People are encouraged to write articles. It is a good way to get started writing.

Another means of in-service training are workshops under the sponsorship of university clinics.

Allied professional organizations such as C.E.C., National Society for Crippled Children and Adults, the Cerebral Palsy group, Psychologists, Dentists, sometimes have meetings to which we are invited and from which we can get much. The regular teachers' conventions often have programs of interest to us.

And of course there is summer school work and study during the school year. Every one of us must be constantly working to improve himself. We all must have graduate training, and *reading — reading — reading.*

However, in our search for knowledge we must never forget that we as public school therapists have chosen a life of service. Huxley once said, "The great end in life is not knowledge, but action." We are out on the front line where the action is and unless youngsters have better speech in June than they had in September, we have failed.

Use of Resources —

Those of us who work in schools have several great advantages over the members of our profession who work in clinics, hospitals, university settings or in private practice. We might mention such advantages as being members of a well accepted and highly honored profession.

The fact that we have access to tax support; then too, we participate in the teachers' pension plans. Our working days are five a week with vacation periods. There are advantages, but the greatest one of all is the opportunity offered to enrich our therapy by using the many resources of the school and the community.

Are you making the most of the opportunities offered in the schools? Let us consider them. First and probably most important is the classroom teacher. She is the specialist on child development, particularly for children in her age group. She is the specialist in education at this level. She, of all the staff, knows the child best. You can learn much from her. Find out all you can about the particular child you are working with, his history, his achievements, his interests, his weaknesses, his play habits, his friends — in short, all possible information. And, in addition, learn how teachers perform in the various grades. While in college you can't possibly get to know what happens in each grade or age level. It is well utilized experience that will give you this knowledge. Observe the teacher's approach to five year olds, ten year olds, fifteen year olds. What vocabulary is used? Sammy Snake, voice and unvoiced, and finally phonemes.

What books are used? What subjects taught? Projects? Types of activities that interest children at various ages? When are they "loners"? When does rivalry develop? When the spirit of the pack? When do they follow leaders or stars? By visiting the classroom you can pick up many helpful ideas. These visits also give you an opportunity to observe your student in daily activities. How does he react to his peers? And they to him?

In return you can give the classroom teacher suggestions for speech helps or activities within her room. Perhaps you can help her understand the speech handicapped child.

High on the list of important people in a speech program is the school nurse. She, too, is your ally. She can give you health histories. She may know the families. She will make the contacts with the medical profession. She will help locate the pre-school child with a serious speech problem and who should be brought to you.

Use the Physical Education Program. You will find in your case load youngsters who are shy, retiring, and do not have friends. You'll also find the aggressive bully who seems to be into something all the time. Interesting opportunities for play and participation, as well as legitimate outlets for surplus energy and ego satisfaction, may be found in the physical education program. Get to know the people who direct this work, visit the playground. Together you may be able to work out a plan that will help some troubled child. A happy child responds well to speech therapy.

Art and Music Programs offer opportunities for self expression. Finger painting or, rather, hand-painting has long been a standard procedure in psychotherapy. You may want to use it. Some children who respond very slowly to the usual speech stimuli will vocalize when their hands are busy in clay. Make a ball — ball — ball — or boy — boy.

Through your Art Department get interesting pictures to put on your bulletin board. Old masters may stimulate discussion. So may modern works of art. Have children produce something in art class and use it for speech stimulation. Have a committee prepare a holiday bulletin board.

Are we making the most of the opportunities offered in music? Work with your vocal teachers on voice problems. Have little ones sing their way to better speech. Develop discrimination of tones. Train ears.

An often overlooked facility is the library. Here you can find books that will furnish stories, rhymes, poems that will enrich your speech activities. Often the library has a picture file which you may use. You can order books for your own professional growth. And the story-telling hour may give some of your pupils a chance to try out their newly learned speech.

We should make use of the Audio Visual department. Through it we can get films and recordings that will add interest to our therapy. We may borrow machines. Sometimes an operator from the science club will run a film. You may wish to use a player only occasionally and, therefore, not have one in your room. Borrow one from this department.

When you go to a school system, learn all there is to know about the guidance or personnel service. It may have on hand records that will be useful to you. Learn how to obtain help from the specialists employed. How do you bring a child to the attention of the social worker or the psychologist? What are the plans for staffing cases? What is the extent of the resources in this department? You may not have many youngsters to be referred, because, after all, you yourself are something of a specialist and capable of handling many problems without calling for assistance; yet, when you need help, ask for it.

In the upper grades and high schools Shop and Home Arts departments offer excellent opportunities for activities that are ego building and may involve speech. In the first place, the long lab periods make it possible to take a youngster out for speech when it is impossible to schedule him at another time. Correctionists report that shop people are most cooperative.

The youngster who has experienced failure in academic subjects may do something in shop that is praiseworthy. Use his speech period to have him describe something he has made. Or have him contribute to the clinic by making a squawk-box, a puppet stage, movie roll, etc. You may want to work with the home ec teacher to help an awkward, unattractive adolescent girl to learn good grooming, diet control, and good manners. Always remember, speech reflects the entire personality. You work with the child — not just his speech.

At the high school level, take advantage of clubs of the adolescent's desire to be a part of the group; to follow leaders. The various organizations in high school will give you opportunities. Sponsor one — Foreign Students Club — Example: Cheerleaders, Indian Relics Club. A speech therapist must be someone in a high school.

Changing personality is noticeable at this age. Complaisance is no longer there. "I'll do it because people I admire have good speech." Try to get a leader into every speech group.

When you go into a new community, find out about and use community resources. Talk with the staff—nurse, guidance people. Look at the telephone book (check professional standing). Read the State Office of Public Instruction manuals and brochures. Call on agencies — Crippled Children & Adults, Health, Mental Health, and Department of Child Welfare.

It is not likely that you'll have many cases who require additional help from outside agencies, but there will be a few and these few will be critical ones.

In these days of increasing aid from the federal government, we as speech people should be aware of what is available. How can we keep up with the rapid changes? Have you considered having a Resource or maybe a Clearing House Committee? It would seem that a committee of that type, composed of representatives from colleges, state departments and public schools, might act as an information gathering and dispersing group. It would keep in touch with Dr. Michael Marge in H.E.W., with C.E.C. Office in Washington, with Dr. Kenneth Johnson, A.S.H.A., with private agencies such as National Society for Crippled Children and Adults, Cerebral Palsy Association, and any others that might have an interest in speech problems. The hearing people, too, might well be included.

Find out what laws and regulations are passed, what opportunities are available, and then pass the word on to the therapists within the state.

This committee, or possibly a second one, might survey the state constantly for areas of greatest needs and help the state office, the colleges, and the schools to coordinate projects that would bring additional services to Alabama.

These are sketchy suggestions but the opportunity is here — now — this year is the time to act. Perhaps you are doing something. Could you do more? Don't let speech be lost in the great drive for help for the disadvantaged. It should be foremost in that project. Is it?

In the time that remains, I'd like to talk about other resources. These are the various organizations that contribute to speech, sometimes indirectly. Teacher groups, C.E.C., psychologists, cleft palate, childhood education — that which is to your interest to participate in and use.

Our national society, A.S.H.A., yes, most of us join, but how active are we? It is true that force of circumstances and events—and not some diabolical planning on the part of a few power-hungry persons, have resulted in A.S.H.A. being run by a few. Decisions were sometimes made which many of us felt did not reflect the thinking of the members. For the last couple of years a committee on reorganization has been at work. I believe a plan is being formulated which will bring the thinking of the rank and file into the management of the Association. Have you read that most interesting study in the current issue of ASHA? The interests of the members in the publications have been studied. The gist of it is that members, the majority of which work in public schools, would like more articles on procedures and practices. Well, there is one way to get them. That is for school people to write. How many articles from Alabama have been submitted to the J.S.H.D. the past year? Don't be timid. Try. If you have an idea, the editors will help you polish your writing.

We as public school people must become more active in A.S.H.A. The reorganization, when passed, will undoubtedly give us an opportunity. Our problem, of course, is to get the time off and the money needed to work on committees, to hold office, or to be members of the legislative body.

First, we must convince school administrators that it is as important for us to be an active member of our national group as it is for him to go to Atlantic City. Of course, the comparison is a bit off balance because in all likelihood if one teacher in all Alabama was an active committee member or officer once in, say, five years, we'd be making great progress.

Second, I believe the state organization should help public school people who are your legislative representatives to finance the trips to national meetings.

Third, school administrators must be educated to the idea of furnishing secretarial help for teachers who do state and national professional business.

Fourth, administrators also must recognize the need for released time to attend meetings, etc. Remember, this is a once-in-a-life-time experience. It won't break any school district financially. And think of the prestige it brings.

In conclusion, we have skipped over the organization of a public school program. We have pointed out some of the advantages found in working in the schools, and we have indicated opportunities for professional growth.

There are great days ahead for you young people. Our profession is just developing. The next forty years will bring many exciting changes. I've had the fun of being in on the first forty. Yours is the fun of the next. Good Luck to you.

SYMPOSIUM

THE SPEECH THERAPIST'S RESPONSIBILITY AS A MEMBER OF THE PUBLIC SCHOOL FACULTY

Mrs. Loretta G. Brown, Moderator
Mrs. Helen Person
Mr. Ted Fuller

Perhaps you are concerned that the person speaking on this topic is no longer primarily employed as a public school speech therapist. Since I had the great fortune of conducting the first public school therapy program in Alabama in the Anniston City School System from 1955 until 1963, (this program began with Miss Van Whaley in 1954), I still strongly identify with the public school therapists in Alabama. It is my pleasure to work with personnel in public school situations almost daily in my present position. Since I have the opportunity of working with guidance counselors, principals, parents, and classroom teachers I hope that I can be objective in dealing with this topic and look at the problem from both sides — that of the therapist as well as that of the public school faculty.

My assumption is that the overall purpose of the Special Study Institute is to improve our services to children who have problems of communication. How can the public school speech therapist conduct a truly effective program? What are some of the factors that contribute to the success of a public school speech therapy program? I would like to indicate the following factors as among the most significant:

(1) A community interested in a speech therapy program. The community would offer both financial and moral support to the therapist. The Parent Teacher Association, various Civic Clubs, Garden Clubs, City or County Government, etc., would be informed of the program and interested in its welfare.

(2) An interested school administration which will listen to the problems of the program and attempt with the therapist to find solutions.

(3) An interested school faculty which will endeavor to work with the therapist in finding time for youngsters to attend therapy, in creating ways of handling youngsters with speech and language problems in the classroom, in offering other remedial services when needed, etc. A faculty well oriented to the program and accepting of the therapist will be of great assistance.

(4) An effective and interested therapist, prepared to do her job.

(5) A suitable place in which to work, enabling the therapist to carry out her duties satisfactorily.

(6) A sufficient supply of equipment and therapy material. A telephone should definitely be provided for the therapist.

(7) A realistic case load which will allow the therapist to work effectively. Both the therapist and the school administration must have the strength to maintain this realistic case load and not overload the therapist.

(8) A sufficient number of therapists to serve the system adequately.

(9) Supervision of the program by a person certified by the American Speech and Hearing Association who can guide and direct the therapist in her activities.

(10) Additional referral sources and resource persons such as a guidance counselor, school nurse, reading specialist, psychologist, pediatrician, otologist, psychiatrist, etc., available to assist in diagnosis and to make recommendations for management of the case.

To sell a program of speech therapy to the community, the administration, and the faculty, the therapist would do well to become very involved in her program. Involvement seems to be one of the traits of most successful therapists. To be involved in the speech therapy program of a certain public school system, one must completely identify with that system. During my training and during my professional experience in Alabama, I have noted a reluctance on the part of many students in speech and hearing therapy to resist working in the public school situation. Many want to begin immediately in a Clinic in a Medical School setting or in a Rehabilitation Center. I feel that the experience I gained in the public schools better prepared me for my current position than any other activity I could have chosen.

Pride in the public school program on the part of the therapist is very important. We should all be proud of the work done in Alabama, for we have many excellent programs. But of course we need to improve and we need many more programs. The pride of the individual therapist in his or her program will be quickly communicated to other faculty members and to the community.

The speech therapy services offered in the public schools should be second to none in quality. These programs are the backbone of our profession. Each therapist must see to it that his or her program is the best that he or she can possibly offer. If there are problems then solutions must be sought — not acceptance of the status quo without efforts to improve the situation. Principals, supervisors, and the superintendent must be contacted to seek their advice and assistance. As in any other program, in the final analysis, what goes on between the therapist and the client or student is the true measure of the program. Any factors which interfere with this relationship must be improved.

Public education will become better and better because of the interest of our state and our nation in the public schools. Therefore, we shall look forward to an ever increasing number of public school programs of speech therapy as well as an increasing degree of excellence in each of these programs. Let us all be sure that Alabama has an excellent program.

We must be practical regarding the extent of involvement of the speech and hearing therapist as a member of the public school faculty. Her special skills must be put to work as much as possible. Ideally there should be some participation as a faculty member to give her a sense of identity and comradeship with faculty members. However, the participation must be to a limited extent, and not enough to reduce the goal of the program. The size of the system will have a good bit to do with the degree of involvement. The smaller the system, probably the more involvement that is necessary. The extent of involvement will to some degree determine the impact of the speech and a hearing program upon the total school system. However, it must be remembered that the most significant factor will be the effectiveness of the speech therapy. How much the program aids the individual children involved is the true measure of the program. If the therapist does not accept some of the usual duties of the classroom teacher or other members of the faculty, there will be some resistance on the part of the faculty to truly accept the therapist and the program as part of the public school situation. However, the therapist must be very strong and must insist on the time necessary to carry out the purposes of the program. For example, if she can be making home visits after school or having older children for speech therapy sessions, I feel that she should definitely not have such responsibilities as bus duty or hall duty. Home visits are a must to reach some parents and to provide aid for some children. This would be a far wiser use of the therapists time than some of the policing duty of the school. Actually, these duties should not be carried out by teachers at all, but should be delegated to sub-professional persons who do not have the special skills of classroom teachers, principals, or special class teachers. However, if the therapist is walking across the playground and notices two children engaged in a fight, certainly she should participate as a faculty member to the extent of terminating this activity. At the beginnng of school she could possibly help with the registration, selling supplies, etc. A spirit of helpfulness to faculty members when her particular duties are not in full swing will be greatly appreciated and will be repaid by the teachers many times over.

I think that a delicate balance must exist between the duties to the faculty and the duties to the program. The speech therapist must ever stand firm to protect the interest of her program. For example, if she needs to do some individual work with a certain child, then she should endeavor to provide this time in her schedule and to fulfill this need. If she must spend extra time in parent conferences this must be explained to the supervisor or administrators and she must carry out this function. Activities of interpreting her program to the public are necessary. She will need to be absent from school to carry out some of these engagements while speaking to civic clubs, garden clubs, etc. At times she must provide certain activities for children which are not commonly followed in general classroom procedure. If a child needs to move around in the classroom during the day, then the therapist must demand for herself the right to let this child move about in therapy. Also she would do well to confer with the principal and teacher as regards the needs of an overactive child. If a child needs more positive reinforcement in the classroom, a calm and more relaxed environment, then the speech therapist's duties are to explain these needs in faculty meetings or in conferences to encourage the teacher to provide more suitable environmental factors for this particular youngster.

Ever paramount in the speech therapist's planning must be the meeting of the various needs of the youngsters enrolled in her program. Time for proper planning of activities, the recording of information concerning each child, writing proper and complete reports, making appropriate reports to administration and faculty, etc. are activities that cannot be ignored if a proper program is to result.

The speech therapist will need to attend some faculty meetings. There is no need for her to attend every faculty meeting as there are many other ways she could be spending her time. However, she should meet with the faculty of each school she serves each year. This meeting would provide her with an opportunity to explain her program, to ask for assistance with schedules, to discuss common problems, to discuss certain problem children, etc. Her attendance at faculty meetings should be announced in advance so that teachers will anticipate her coming, have certain referrals ready for her, have the information that she will need, and have ready the questions which the therapist may assist in answering. The therapist should offer to attend a faculty meeting each year, and should request the opportunity of discussing her program with the faculty.

What of P. T. A. meetings? If a therapist has several schools it will be impossible for her to visit more than one P. T. A. meeting in each school. But again this is a very important responsibility. Her attendance at the P. T. A. meeting should be announced in advance so that parents may come and make the initial contact with the therapist. After this it will be much better for her to have a private conference to discuss the child with the parent. Again the therapist should offer to attend the P. T. A. meeting and ask for the opportunity of discussing her program with the parents in that community.

The therapist will do well to be involved with the faculty and the P. T. A. to the extent of having a committee in each school to work with her in solving various problems. This committee of teachers could develop the policy regarding the scheduling of cases, the carry - over of activities into the classroom, additional referrals necessary for children, transportation problems, equipment needs, material needs, etc. A parent committee can assist in many ways such as aiding with supplies, community resources, etc.

A committee of classroom teachers can do much for the therapist. This would be especially helpful to the beginning therapist in discussing with her, particular problem children. The therapist's attitude will be most significant in the success of such a committee. Let us hope she will be willing to listen as well as self confident enough to insist upon what she feels is appropriate.

It is very important that the therapist carry out her special program in a very efficient way. Listed are several factors which may aid her in her efficiency and may improve her relationship with the faculty:

(1) Forms should be made available to teachers and principals which may be checked to allow a quick referral of children to therapy.

(2) The schedule of the therapist should be available to the principal and should be kept up to date. A therapist should adhere to the schedule very promptly. If for any reason a change in the schedule is necessary, the school must be notified.

(3) The therapy program should be carried out on schedule so that children will not be delayed from returning to their classrooms.

(4) Therapy should be planned and lesson plans made out well in advance.

(5) A record should be kept on the activities of each group or each individual child each day so the therapist knows exactly what has been done with each child.

(6) A very accurate record of attendance must be kept with the absences of all children noted.

(7) Information regarding the waiting list for therapy should be kept correctly and the policy of admission to the therapy program should be available in each school.

(8) Reports should be written regarding each child and sent to teachers, principals, and school administrators. Perhaps a different report may need to be written to the parent. An annual report of her activities should be sent to the principal of each school, to supervisors, and to the superintendent. Certainly the Board of Education should receive information regarding her activities.

It is important that the speech therapist be known in the system. Public relations material which might be released through the Public Relations Committee of the local Teachers Association would be helpful. Certainly any problems or factors limiting the effectiveness of her program should be discussed with the superintendent. The therapist should feel that the superintendent is vitally interested in the program, and willing to assist her in finding solutions.

The need for continuing education on the part of the therapist should be remembered. She should strive for full certification by the American Speech and Hearing Association. Fellow faculty members will have advanced degrees and will be continuing their education. Certainly the person who is a specialist dealing with children with special kinds of problems should continually keep up with the profession. It is very difficult to keep up with the reading material in our field currently, but the therapist should endeavor to keep herself abreast of developments.

What of membership in professional organizations? Certainly the therapist should be a member of the American Speech and Hearing Association and the Speech and Hearing Association of Alabama. How about the Alabama Education Association and the National Education Association? The therapists often say that since they belong to ASHA and SHAA they will not need to belong to these other organizations. However, other special teachers belong to their particular organizations as well as the AEA and NEA. Speech therapists must stop to remember the contributions of the AEA and the NEA to our field. The Alabama Education Association should be supported as it is the organization working with the Governor and the State Legislature in acquiring adequate appropriations for teacher units, increased salaries, building money, supplies, etc. The fact that Alabama has the number of special education units now in existence is due in part to the efforts of the members of the Alabama Education Association. Also the level of salaries which we now enjoy in Alabama is due in part to the efforts of the Alabama Education Association.

The National Education Association has great influence at the national level. We should be represented in the membership of the largest education group in the country. The NEA not only works with the congress in educational appropriations, but is influential in research grants, educational foundations, various studies, and supports all types of work with handicapped children.

The topics mentioned previously have all related to the role of the speech therapist as a member of the public school faculty. The administration and faculty must realize that we are also very different from other faculty members. We meet different needs of children and we have different requirements to meet these needs. We must be allowed to be ourselves and to function so that we can effectively do our job. We must have conditions which will allow us to work effectively. Our standards must be held as high as possible. Our enrollment must be small. Special equipment will be needed. Individual work is necessary at times, and our total case load must be light. If we take too many students, then we have defeated our purpose and the goal of our work is lost. We must not be afraid to take our stand in terms of how we can most effectively offer our services to the children of the public schools. Also we must offer our services to the public school faculty and to the community so that they are well oriented as to what we are doing and how we are going about it. We must ever be careful that we are using our time wisely and effectively.

Evaluation of what we are doing and how we are doing it is important. It is a mistake to try to isolate our program too much from the other faculty members and the other children of the school. An open house to which we invite teachers and friends of the children we are now working with would be helpful to educate each school as to what goes on in the speech therapy classes.

In summary then, the speech therapist has a very special role as a member of the public school faculty. She must use her very best judgment in creating a delicate balance between her activities as a faculty member and her activities as a speech therapist. She must ever keep before her the goals of her program and jealously guard her time to enable her to carry out such plans. I have talked of involvement in the program as a key to her success. Also I have discussed identification with the public school faculty and program as a vital factor. The therapist must advertise and explain her program to the administration and the community. The accomplishments of the speech therapy program as well as the needs should be communicated to school officials and faculty members. In the final analysis the therapist must be strong enough to maintain a very high level of professional behavior at all times. Her determination to protect her program and to provide the finest service possible for the children with communication problems will afford her true role as a member of a public school faculty.

THE SPEECH THERAPIST'S RESPONSIBILITY IN IDENTIFYING PROBLEMS OTHER THAN COMMUNICATION AND MAKING REFERRALS

Mrs. Helen Person

The identification and referral of problems other than comminication problems by the public school speech therapist will concern problems related to speech and hearing and language problems or actually accompanying a known communication difficulty in almost all instances. When we talk about problems related to, that gives a broad base doesn't it? Among a certain group of friends I am known as the "communications nut" because in any discussion of depth; foreign policy, economics, education, or politics, I always seem to finalize my opinions with, "It is primarily a communication problem!" I firmly believe this. Really — doesn't every aspect of his being, his growth and development, physical and emotional health and his social adjustments vitally relate to and influence any child's desire to communicate, as well as his skills in presenting himself with the tool oral language? And certainly this is the most needed, most easily accessible communication tool or set of tools any human possesses. So we just can't divorce oral communication or any form of communication from anything.

Suppose the word "oral" is eliminated and we deal with "communication problem," then this does indeed involve every aspect of a child's learning. All his perceptions and his expressions. No processes of communication or learning takes place without a structure of some form of language, simple though it may be in the beginning. "Lur-lur" or a reasonable likeness of such as you well know can mean "water" or "give me a drink of water." And has meant this exactly, as a matter of fact! This is symbolic association — language, and when the listener, mother, knows this means "water" that's communication! It must become more complex. Anything that impedes a child's perceptions, his associative processes, and/or his expressions in any form impedes his communicative skills and becomes the concern of a professional person dedicated to problemsof communication.

I feel that we as speech, hearing and language therapists in the public schools are missing a portion of our mark by not being better trained in more areas of what the classroom teachers call part of their language arts curriculum — reading — so that we might better help in cases where the child needs remedial reading. That opens a whole new profession doesn't it? Shall we have another workshop? Many of the reading problems in our schools are language problems unrecognized as such. In the Birmingham area we are very fortunate in having a program of help for the dyslexic child. This program has operated, I understand it, in cooperation with one of our neighboring school systems. Dr. Shedd at the Alabama Medical Center, is heading the work done in evaluations and diagnosis.

So most of the children who come your way with a problem other than a communication problem, will also have a speech, hearing, and or language difficulty. This is not always the case.

The speech therapist in the public schools does indeed have a place in the organization that is special — not that the therapist is in any way (in almost all cases) given special considerations, like desirable space in which to work, enough time with the children and teachers or time on faculty in-service training programs or P.T.A. programs. She is special in that the nature of the time spent with the child is dedicated to the improvement of a difficulty or difficulties this child may have, specifically a problem involving communication. Here then is a person on the faculty of the school dedicated by her profession to dealing with difficulties, some more than just simple difficulties, some major problems to the child, the teacher and the parents.

Thus the speech therapist becomes special in her relationships with the other faculty members and to the children as well. She stands for "HELP FOR THE PROBLEM" —, I sincerely hope, a real comfort to many sincere classroom teachers. Many times the teachers and the principal will make this association in their relationship with the therapist—

HELP FOR THE PROBLEM

HELP FOR THE PROBLEM

Because of her initial motivating forces, the personality structure that is sincere, flexible, willing to serve, the knowledge and training that go into the make-up of a speech therapist, these classroom teachers — and sometimes principals do come for help with problems other than problems of communication. And it is a responsibility that the therapist should be ready and by virtue of her preparation and knowledge—willing to meet.

Perhaps you have stood with a classroom teacher waiting as the children came into the room as I have and casually asked, "Does Bobby always keep his mouth open to breathe?" The teacher replies. "Why, I don't know. But I'll watch him carefully!" And the result is that he does always breathe with his mouth open, according to the mother even at night. When the mother gets the child to the doctor, the doctor finds a nasal obstruction that should be removed. This child may or may not have had any communication problem.

A fellow speech therapist in Tennessee once told me about saying to a classroom teacher as they watched a first grade class come into the classroomone morning. "Johnny's coloring certainly is unusual today, isn't it?"

"You know, I've been so concerned, his coloring is always that blue. I think I should talk with his mother, don't you?" The result was, a child who had not received medical care in his little lifetime, was found in one of the semi-indigent health centers to have a heart mal-function. Perhaps the concern, the awareness of the speech therapist played a part in getting vital medical care.

What then are some of the problems other than communication problems that are likely to come your way in the structure of the public schools? They are many and varied. The structure of the responsibility for recognizing and referring these problems may be determined by the individual school's organization and policies. The extent of this responsibility may be determined in part by the local school or schools, whether rural or urban, the community in which the schools are found, and other personnel available. The extent of this responsibility will depend on the facilities available. The comparisons perhaps of the rural schools to those of the urban areas which are in close contact with medical and dental centers for learning research may show the differences in how far the responsibility of the speech therapist does go.

Regardless of where you are and the procedures that surround you and perhaps in many instances even bind you, when a child comes your way with a difficulty that you know needs attention and attention that you as a speech therapist cannot give you are duty-bound to do your best to get this child to the proper hands. How, as I have pointed out depends on your particular organization and you must know that! You have probably found that procedures can differ from one school to another even within the same school system. Make it your very serious business to find out "HOW" within each school even if it means finding it out the hard way. Like "Didn't you know that all phone calls of that nature must go over the principal's desk?" And of course how you handle a referral will depend on the nature of the difficulty.

The severe problems of speech and or hearing, the therapist easily recognizes and refers for help to the local Hearing and Speech Center. The other types of problems may fall into one of several groupings. These problems may be:

DENTAL PROBLEMS

MEDICAL PROBLEMS

SOCIAL OR EMOTIONAL PROBLEMS

LEARNING PROBLEMS

Dental problems the speech therapist sees often. Although in many instances the problem is closely related to a communication problem, a speech difficulty, speech therapy cannot make all the corrections. With the very young child it may well be the speech therapist who first observes the dental caries and the simple need for fillings. Later with older children the mal-formations, mal-alignment, mal-occlusions obvious to her will certainly need the work of an orthodontist. With a tongue-thruster who substitutes "th" for "s" or in any other way distorts sounds or substitutes them, speech therapy alone will not bring those teeth back into line. And certainly this will have been pointed out to the parents in conference. It may be possible that the parents are not able financially, or for other reasons, do not follow-up the speech therapist's recommendation for dental or orthodonic care. If there is a school nurse, her follow through as well as the support of the classroom teacher would reinforce the need to the parents. In some cases going to a private dentist or orthodontist is simple, in other cases appointments need to be made for the parents at Public Health Centers or other civic dental facilities. The speech therapist can easily know the facilities available and how the principal of the particular school likes to handle referrals through the school. That is those referrals not altogether taken care of by the parents themselves. Many times the individual principal likes to handle the details to the "non-private" referrals himself. Here again the therapist's awareness and interest can be the motivation force to achieve action with results.

This leads to the medical problems that come to the therapist's attention, and these can be myriad. You first think of chronic colds and ear infections that interfere with articulation, quality and auditory acuity. And to re-emphasize — no speech therapist proceeds with any voice therapy without medical supervision. Certainly this is in the realm of "referred for communication problems", but I would like to urge all of you to remember to help to educate parents and teachers of the need, the necessity for medical evaluation before beginning any therapy. So often you hear, "But Johnny has always talked like that."

All the problems that accompany a major nasal obstruction may not be communication problems, but you're not as likely to effect quality change or articulatory improvement if there is a speech problem, without someone else's help in removing or improving that nasal obstruction. How many of you have known classroom teachers to be unaware of a child's temporary hearing loss due to cold and/or ear infection? You may have suggested that you could check the hearing with the audiometer when the child seemed to be hearing less well, and if indeed he did show less acuity, then neither you or the classroom teacher hesitate to refer the child to the doctor. Those with a long-term or seemingly permanent loss must go for medical help before thorough evaluation of hearing in a Hearing and Speech Center.

There are cases less related to communications problems. What of the child who is chronically fatigued. Conferences with parents and especially the classroom teacher must support your analysis. You see the child such a small part of his day. During the school year mothers sometimes do not realize that a child is suffering with certain symptoms because he is away from her a great part of his waking day and he is supposed to be somewhat tired after a hard day at school. The classroom teacher sees him for the biggest continuous period of time and is in an excellent position to confirm your observations. The child's sleepy attitude, his lack of sufficient sleep, of breakfast, or one symptom of some difficulty that needs the doctor's care.

If you suspect neurological complications, then you need all the possible help you can get in observing. Here again in conference you point out the traits that cause you to suspect, or point out results of tests that you may have done and ask the classroom teacher to observe during the rest of the day. Some parents may have had some idea that the child's performance at school was poor, but may not have identified the difficulty in any respect. Any recommendations you might make about trying to find the real nature of the problem is more likely to be well received if they think that the therapist and the classroom teacher agree about the referral. Many parents will follow-through from a conference after you have asked: "Have you ever talked with your doctor about Jimmy's clumsiness, his poor coordination or even his difficulty in handling a pencil for writing, his confusion about dominance, his inability to pay close attention for any length of time, his easy distractibility?" In this area of neurological difficulties you become very aware of possible brain damage, perceptual-motor difficulties and learning problems. The history of speech therapists in the public schools has always been full of concern for the child who has "aphasic" characteristics, the "aphasic-like" or the aphasoid child. These children present many complex problems and I think their accurate diagnosis is very challenging. For these reasons the public school speech therapist should not assume this responsibility without help. The classroom teacher's awareness of the reason for your concern is reenforcing in making identification for referral. With the classroom teacher and perhaps the principal the school psychologist may be the best first referral. Particularly would this be true if there is no physician close to the child and who would be truly aware of the difficulties of a possibly "asphasic" child. Of course to have neurological, psychological as well as thorough speech and language evaluation is the most desirable first step. Sometimes parents need more "evidence" before thinking it necessary or even helpful to go to that extent. It is also possible that the parents will not cooperate to any extent and you have no evaluations other than your own. You know that this child is in trouble, so you give as much as you can to the classroom teacher and keep working on those parents.

Suppose you have in one of your classes a child who is not able to keep up with the others in learning new sounds or whatever, who is showing little or no improvement in actual carryover, whom you suspect generally to be "slow." What do you do? Perhaps you have access to some equipment and can do a screening test of intelligence. You find that this child's performance rates well below what it should for his cronological age. Then what? Go to his classroom teacher and ask for any test results she may have and any in the permanent record from past years. If these records all indicate a slow learner or a retarded child then without question a thorough psychological evaluation by the qualified psychologist is vital. We feel that facilities in Alabama are good for the evaluation of those children who are thought to be mentally retarded, and the facilities are getting better. So making the referrals and getting the evaluations is in most instances not much of a problem.

Alabama facilities are also good for the evaluation of emotional difficulties. And aren't you many times the first to be aware of some less complicated, less bizarre emotional problems of children in the public schools? In small groups, with more opportunity to talk, these difficulties may be known to a speech therapist long before the classroom teacher is aware. This is particularly true with the child who stutters because your therapy consists of so much parental counseling. Actually getting the child into the proper hands may not be easy. This brings out great need for time to work with parents.

Referrals are worthless unless there are results. Establishing a professional tie with the medical people, especially the pediatricians, in your community can help you to make your referrals more effective. How many mothers have you heard say, "I'll jump over the moon if Dr. ________ tells me to." Or perhaps more frequently — "Dr. ________ says that Johnny will outgrow this speech." I doubt that any of you public school therapists have the time to write reports to the pediatricians, and in many cases with the speech and hearing problems of children in the public schools it is not necessary to have contact with the doctor directly. Once I had a ten year old boy with a mild articulation problem in class. His progress for the first two months was excellent, then about mid-winter he really began to revert to old patterns. Three times I called the mother for conference to say that I felt that David had had nasal congestion for a very long time, he was always tired and inattentive and that I felt that this condition was definitely interferring with his speech improvement. She replied that she was sure that he would soon be better, later that he may have a slight allergy which she did not want to pamper and then that she was giving him a decongestant at night. I knew the family's pediatrician, so I called him to report on David's speech improvement. I asked him to please check the possible congestion and the cough if this boy should come to his office with a sprained ankle, cut finger or some such. It wasn't too long before David was taken to the doctor's office for a routine immunization and although he wasn't to see the doctor himself, the lab technician gave the shots, the pediatrician tactfully managed to see the child and ask about "school." He also tactfully managed to look at his nose and throat and found considerable infection, enough to warrant two ten day rounds of anti-biotics.

While it is the responsibility of the speech therapist to refer these problems other than communication problems, it is *not* the responsibility for the speech therapist to become diagnostician for problems other than communication. Nor is the speech therapist to assume the duties of psychologist, unless in fact she is so trained; nor remedial reading teacher, unless in fact she is, or school nurse or otherwise. In making referrals my emphasis in summary would be:

KNOW YOUR STUDENTS

KNOW YOUR SCHOOL PROCEDURES

KNOW YOUR FACILITIES

WORK WITH THE CLASSROOM TEACHERS

ONCE A REFERRAL IS MADE FOLLOW THROUGH

THE SPEECH THERAPIST'S RESPONSIBILITY IN WORKING WITH PARENTS

Mr. Ted Fuller

Of all the factors that affect the speech and language development of children, the most important is the home, for the home is reflected in the personalities of the parents and in their relationships with their children.

Speech-handicapped children ARE different, but it is important for parents to realize that their youngsters' differences are often the result of the speech difficulty, not the cause of it.

Children with defective speech, as you know, are generally much like other children except for the speech difference. There are exceptions, of course, where the cause is a physical or neurological defect, like a cleft palate or cerebral palsy. But the personality differences that might distinguish these children from others are only those that a handicap — and especially a speech handicap — might be expected to foster. When you consider the importance of communication in a child's development, it is clear that personality differences will be the result of the speech inadequacy.

Without speech, the child's whole experience is sharply limited. Without some form of communication, his avenues to learning are cut off. The things that make for growth, for richness in living, for self-fulfillment are missing. A barrier to communication with others, limits the child's understanding of the world and of himself.

The barrier can, of course, become larger than the defect. Differences can be magnified by parents, teachers, or playmates, by all who come in contact with the child. But the effects of differences can be minimized with the kind of home and family relationships that encourage the child to make a stable adjustment to our world.

The main goal of parent education or counseling, of course, is to help the child with his speech problem. Speech therapists realize that parents play a most important part in the rehabilitation of speech and hearing problems. Studies reveal that parental behavior frequently is a significant factor in, the histories of children with slow speech development, functional articulatory problems, and stuttering. The co-operative parent, invited to visit a therapy session, observing the techniques used, informed in conference as to the necessary part he can play in the home in co-operation with the therapist will be able to avoid counteracting results achieved in therapy, give added help and encouragement to the child at home, and see that he carries out the therapist's instructions for "home work."

Parents can do a great deal to help the child with a speech problem. In fact, much that can be done for a child with a speech problem can only be done by the parents. However, it demands real effort, understanding, persistence, and patience over a long period of time. In some cases it may even require serious reorganization of the entire family's way of life.

A very real danger is that the wrong things may be done for the right reasons. Good intentions are not enough. Based on misinformation, they often become the major cause of the very problem which needs to be corrected.

Tufts and Halliday, in 1959, did a study using three matched groups of children with articulation problems. The first group was given no help of any type to see what effect maturation would have on the children's speech. The second group was given therapy by a qualified speech therapist. The third groups' parents were counseled and told what to do at home to help their children. After seven months no changes were noted with the maturation group. However, significant differences were noted in those children taught by a speech therapist and those children taught by the parents. However, there was no significant difference noted between the group taught by the therapist and the one taught by the parents.

The counseling sessions for parents should be designed to give some general background information in speech development, to help them understand the concept of the normal, to give them some brief introduction into the etiologies of speech disorders, to acquaint them with professional services available to children with communication handicaps, and to make them aware of their own roles in the total process of speech development.

Children referred to a speech therapist for a speech evaluation either do or do not have a problem in speech. In both instances, the parents are usually interested in knowing what they should do to provide speech guidance.

This then is one of the major responsibilities of the speech therapist to interpret the child's speech difficulty to the parents as realisically as the parents are able to handle at the time, using the developmental levels as a guide where possible, and to help them plan a realistic home program, within the limits of the parents capabilities.

A complete speech evaluation of a child requires consultation with both parents. However, individual conferences with parents are usually extremely difficult to arrange in a public school setting. Every effort should be made however, to reach each parent. Individual conferences may be held at home, the school, or by telephone. Home visits are most beneficial because the therapist can get a "first hand" look at the child's home environment.

Sometimes formal parent - education meetings can be held at the school by the therapist where the parents discuss common problems. It is recommended that from six to ten full hour meetings be arranged for the education of parents. In counseling parents, it is imperative for the therapist to know as much as possible about them. This information should include pertinent identifying information, educational status, socio-economic level, disciplinary methods used at home, the parents knowledge of the child's behavior, reactions of parents to the child's speech problem, parents recreational outlets, composition of the family, long illnesses in the home, intense emotional situations, marital relationships, stability of home locations, and the parents love for their children.

Usually parents fall into four categories: those who are embarrassed and reluctant to talk about their child's problems; those that feel that speecn and hearing services have no place in the schools; those parents who appear to like their problems, want to talk about them, but do nothing; and those who are willing to hear the truth and do something about it. Of course, usually those children whose parents are willing to do something about the problem make the most progress in therapy.

Before the therapist asks the parent to give any specific help with speech correction at home, he should be sure that the parent can help.

The parents should know something about how speech develops normally, and what can happen to cause a speech problem. They should realize the kind of conditions in the school, in the home, or in the neighborhood that tend to contribute to the speech difficulty. They should also understand what kind of conditions in the child's total environment makes for normal speech development.

With such information, parents can better realize what kind of speech standards they should set in the home. They can help the speech therapist by becoming good observers and reporters. Most important of all, they can help by developing the right attitude toward the defect and toward the child.

If the parents are able to help, the therapist should demonstrate and explain what techniques can be used. Discussions and demonstrations should be supplemented by supervised observation of a therapy session. Parents should not be given the full scope of the rehabilitation program at first. The information should be dispensed bit by bit within the realm of the parents capabilities.

The parents can seldom be used in the beginning steps of therapy. They tend to progress too quickly, even when they know what to do. However, they can be of particular benefit during the carryover stage. It is best if the parent works with the child in a certain room in the home each time. This will tend to identify the speech work as demanding different attitudes from those which ordinarily exist between parent and child. Speech periods should be short, well planned and motivated.

In conclusion, let us not forget that the child with a speech problem is first a child and should be accepted for himself and without reservation. This means more than permission to be in the home, more than a pleasant atmosphere, more than mere tolerance of his efforts. He must find positive satisfaction in the environment, knowing that he is secure, that he belongs, and that he is respected. Also, we must remember that the desire to learn must come from within the child. It cannot be imposed from without. The child must be encouraged to be a part of the family, to participate to the level of his abilities. Where his poor speech is not a handicap, he should be held to the same standards as the other children in the family and given every opportunity to gain prestige with them.

Finally, let us remember that the program must be consistent. It cannot be an occasional drawing of the child into the family activity. The goal of speech learning must be a part of all that the child does.

SOME MEDICAL ASPECTS OF SPEECH PATHOPHYSIOLOGY

Dr. William Daniel, Jr.

It has been said today that our goal is not the absence of disease alone but the optimal growth and development of the child physically, emotionally, intellectually, socially and morally. All disorders of communication whether caused by decreased hearing, use of inappropriate language, erroneous sound interpretation, poor presentation of words and phrases, mental retardation and the entire gamut of causative medical conditions are of great importance. You are undoubtedly familiar with most of these.

It would also seem appropriate to issue a warning to you. It has become fashionable both in medical literature and practice to explain many difficulties, including speech disorders, by diagnosing minimal brain damage or minimal brain dysfunction. It is true that there are some patients who exhibit this syndrome. It is also true that abnormal electroencephalograms may be obtained from some of these children. But, remember that interpretation of EEG's in childhood is difficult and is a personal opinion of the evaluator. An abnormal EEG does not necessarily permit a diagnosis of minimal brain dysfunction, which condition usually is associated with speech abnormality. We know that most children now having a diagnosis of aphasia or of minimal brain dysfunction are in reality mentally retarded to various degrees due to unknown causes. Therefore, let us not use either of these diagnostic terms as a cover for our ignorance or as a wastebasket diagnosis.

My presentation in this trialogue is concerned with the effects of speech difficulties on children and the adults into which they metamorphose. We, like you, have long been aware of the relationship of speech and health but at the Adolescent Unit of the Medical School of Alabama we seem constantly confronted with dramatic examples of both poor speech disrupting good health and poor health disrupting speech.

We have learned that speech may be normal, whatever that is, under usual circumstances but completely abnormal under other conditions. An eighteen year old boy was seen at our clinic for a routine examination and his speech screening test was remarkable. The boy had a paper form to be filled out stating that he was physically fit to work. He was successful in obtaining a job through a summer employment agency working as locker boy in a men's club. After several weeks he returned to our clinic because of headaches for which no cause could be found. It was apparent that the headaches had begun about the same time he began to work in the locker room. In a lengthy discussion with this boy, he was asked to discuss what he did, what were the conditions under which he worked and so forth. As he began to talk about the duties, what went on in the locker room and the like his speech changed. He began to make slips by using the inappropriate word, had slight difficulty in pronunciation and it was evident that this bothered him. It was also apparent that he was becoming more nervous. The subject was pursued and soon he had even greater difficulty speaking. Suddenly he developed a severe headache. At this point he was told that now was his opportunity to "get it off his chest." With that he blurted out that he thought he was a homosexual and working in the locker room with boys and men taking showers upset him and he was afraid they could look at him and tell that he was homosexual. He also stated that he had great difficulty in talking when he was asked questions at the club and that he would have quit except he needed the job. I know that a physician, on a routine physical examination, could not tell that this boy would have speech problems and I doubt that a speech therapist could have done so.

Stress can always cause disruption of speech, usually temporary, but occasionally permanent. One fourteen year old boy was seen who had difficulty speaking. Once again this had a definite date of onset — a night when his father forced the boy to sit in a chair and watch while the father killed the mother with a knife. Milder forms of stress may be associated with emotional conditions which even have a third factor, social acceptance. An affluent teenage girl attended her first mixed party with a date and during the party, which until then had been pleasant, one of the group asked the girl her father's occupation. It so happens he was a proctologist. The girl so stated. With a strange word floating in the air, other adolescents turned and asked, "What is that?" You can imagine the sudden stress of the girl with all eyes on her, trying to find an acceptable word for proctologist, her emotions rising to the surface and finally embarrassment ending in tears as she fled from the party saying, "I . . . I . . . I can't . . . tell." This girl is not a candidate for speech therapy but does need an acceptable synonym.

Social acceptance is of extreme importance to adolescents. As a group they are self-oriented, interested in their bodies, in their appearance, in their relationships with their peers. They avoid anything which may make them different. One girl who was not popular, though very pretty, came to us because of poor vision. It was found on our screening examination that she had speech which was annoying, talking with air escaping from the molar area, later lisping. Finally after listening to her, she was asked, "When did you begin speaking like you do?" She pretended not to know what was meant by the question and when it was explained further, tears burst forth and she sobbed that she hated the way she talked and didn't have any friends. She was referred for accurate diagnosis and therapy and, unlike Cinderella, she soon did not have to leave the party at midnight. Whether the associated blonding of her hair had more to do with this than her speech improvement is unknown; however, she no longer hated herself and was "socially acceptable." It has also been amazing to us in the acceptance or rejection of the teenager by his peers according to language. As Henry Higgins so beautifully demonstrated we do tend to group ourselves according to words and their pronunciation. Many times there is no real speech defect but what I call "habit" in pronunciation. For centuries we have had jokes told in dialects, rural versus up-town talk, and not long ago it was possible in some cities to tell the area of town where the patient lived just by his accent. I know a doctor in Alabama who came from an isolated community and whose parents were tenant farmers. He must be given credit for obtaining higher education under many handicaps yet even today he knows that his pronunciation and the words he uses immediately "label" him. Although he is now 35 years of age, he is seeking speech therapy to help his pronunciation and help make him socially acceptable in the society he prefers.

Every adolescent, as he develops, should have ideas about a vocation. He may change his ideas many times, but during the teen years vocational awareness must come as part of optimal development. Adolescent boys and girls have much more sense than we are apt to admit and often their serious thoughts are hidden from us. Once again, it has been interesting in our Adolescent Unit to learn how often speech difficulties may affect the adult life of one of these boys or girls. One girl wishes to be a speech therapist because she has been treated for several years yet she fears that her own difficulty may prevent her helping her patients. This reminds me of the psychiatrist who finally admitted that "I went into psychiatry because I thought I might be helped." I don't completely understand this reasoning, but I imagine the speech therapist could do a better job with her patients. A boy wants to be a trial lawyer—really a judge—but he stammers and doesn't believe he could influence a jury very well. Another boy wants to go into the diplomatic field, "work for the State Department in a foreign country," but he has such a rural accent it is doubtful that he could ever master a foreign language. A girl had a summer job as a clerk in a department store but was so shy that when a customer asked questions about the merchandise the young clerk stammered, became embarrassed and was finally transferred to the department concerned with pricing articles. Failure in any of us is undesirable but in an adolescent boy or girl may be disastrous.

Lest you be left with the idea that we believe everyone should speak perfectly—perfect being your and my criterion—let me say that homogenization of speech is not our aim. I am reminded of the boy in college who pronounced Spanish words with such a Southern drawl that the teacher corrected him. He replied, "Aw, Miz Smif, ef I tawlked lak you do I could'n eben go hom cuz they's laugh at me so." Thus it would seem to be important to at least consider the environment in which the individual lives before correcting his speech too drastically. We hear much these days about The Second Language, the language of the Southern Negro which often prevents him obtaining a better job. Now we have seminars presented to teach correction of this. In our own Adolescent Unit we plan to have group sessions with Negro teenagers and see what improvement we can make. It should be an interesting study.

In the evaluation of speech and the therapy used, we urge you to be aware of the developmental maturity level of children, especially adolescents. It is important to remember that the sequence of development of all human beings is the same but the timing of maturation is specific for each individual. The fourteen year old boy who is six feet tall and weighs 175 pounds is as large as a man—but his brain is only fourteen years old. Being as large as an adult creates psychological problems and even the speech therapist may expect him to react as an adult. Conversely, the small slow-maturer of sixteen may also have problems but mentally he reacts at a relatively mature level. Thus testing and treatment must be correlated with maturity status and not chronological age.

It seems imporant to remember that in a relatively short time during early puberty that the maxillary area of the face grows rapidly. Can you anticipate the effects of these anatomical changes as related to speech therapy? It would appear likely that some methods need changing to accommodate the anatomical and psycosocial changes occurring during puberty. Motivational aspects of any therapy assume tremendous importance in this age group of patients. And here, the personality of the therapist assumes tremendous importance. The grouchy therapist who constantly criticizes the adolescent—and this does happen—is doomed to failure. He will show her that all her efforts cannot make him change. Thus academic degrees, book learning, are useless if the therapist cannot relate to the patient, cannot stimulate his desire to improve, cannot motivate him. Self-examination is necessary for all of us.

One needed improvement in the field of speech problems is education of the physician. It is common for the physician to refer a patient to the speech therapist only when the child stammers, lisps, or has a cleft palate. Unfortunately, we doctors receive very little training in medical school which would qualify us as having even a smattering of knowledge in speech disorders. Thus, like the physician who prescribes an "1800 calorie ADA diet" for his diabetic patient and expects the nutritionist to teach the patient so we find the physician who recognizes a speech defect sending the child to the speech therapist for "speech therapy." He really has no idea what the therapist can or cannot do, no instructions for the therapist, and no method of analyzing whether a good result has been obtained, under the circumstances, or not. At the present time we in the Adolescent Unit at the University of Alabama Medical Center screen each new patient for speech defects. If one is found, we refer the patient to the Speech Clinic for diagnosis and recommend therapy. We are learning and are grateful for the teaching by competent speech pathophysiologists, for like the alchemist of old we hope speech pathophysiology may turn the baser metals (medicine, dentistry, speech) into gold of a unified concept which considers the whole patient and not just his tongue, or palate or sounds that emerge there from. In this unified concept we are learning that we must consider many factors which were not apparent before.

This has been a rambling discussion of some of the problems related to speech and language seen in the Adolescent Unit at the University of Alabama Medical Center. We know that many of these problems are medical only in that the physician may learn of them, medical because the physician may be the one to pass on valuable information to the speech professional, medical because the very term means the whole boy or girl and not a part. We are learning that, as with so many conditions in medicine, prevention is easier and cheaper than correction. Early diagnosis, early prevention, early correction are also aims of speech pathophysiology, that melding of medicine, dentistry and the speciality of speech in its widest field. We believe we are at the beginning of a long and interesting study which should be of great value. The boy or girl with communication difficulties can never be a well-adjusted, productive member of adult society, and we hope that we may be of benefit to many of them.

TRIALOGUE IN SPEECH PATHOPHYSIOLOGY

AN INTERCLINICAL APPROACH TO SPEECH AND LANGUAGE DISORDERS

Communicologists
in the Total
Health Picture --

Gwenyth R. Vaughn, Ph.D.

A SPECIAL STUDY INSTITUTE

State Department of Education
Montgomery, Alabama
October, 1967

COMMUNICOLOGISTS IN THE TOTAL HEALTH PICTURE

Gwenyth R. Vaughn, Ph.D.
Associate Professor and Head, Section of Speech Pathophysiology
Director, Speech and Language Clinic

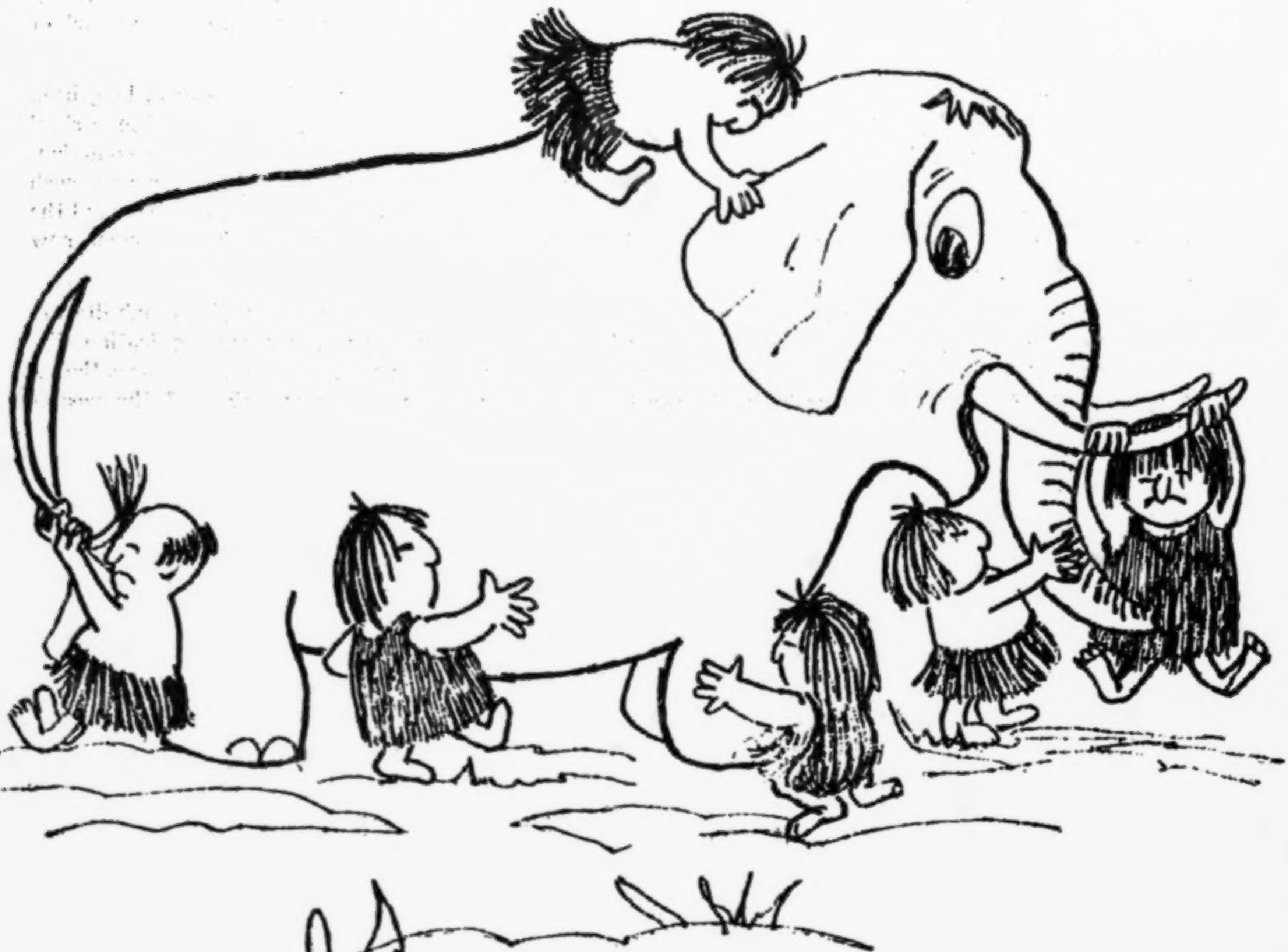
Legends tell us that Aesculapius was the first physician and that he became so skilled in medicine that he could restore the dead to life. His remarkable abilities angered Pluto, who persuaded Jupiter to destroy him with a thunderbolt. At the bereaved Apollo's request, Jupiter then placed Aesculapius among the stars.

In Greek art, Aesculpaius was represented as a strong, earnest youth bearing a serpent-entwined staff. The serpent was the ancient symbol of health because it could shed its skin and appear young again. Modern physicians and dentists have adopted the staff and serpent as a symbol of their art of healing.

All of us who work in the many related areas of Health, Education, and Welfare have long been aware of the tremendous achievements of the medical and dental disciplines in attaining the virtual elimination of many of the diseases which have plagued man throughout his history. These accomplishments have given impetus to preventive procedures and drawn attention to the importance of speech functionalism as an additional goal in health habilitation and rehabilitation. The satisfaction in and the satisfactoriness of appropriate speech as a part of the total body health function have become new measures of successful health procedures.

The use of the terms satisfaction and satisfactoriness has long been common to the rehabilitation counselor. These words have not, perhaps, been used as facilely by persons in the communication disciplines. Satisfaction is defined as the response of the client to his own state of rehabilitation; satisfactoriness is the degree of functionality evidenced by on-the-job performance as seen through the eyes of the employer.

THE BLIND MEN & THE ELEPHANT



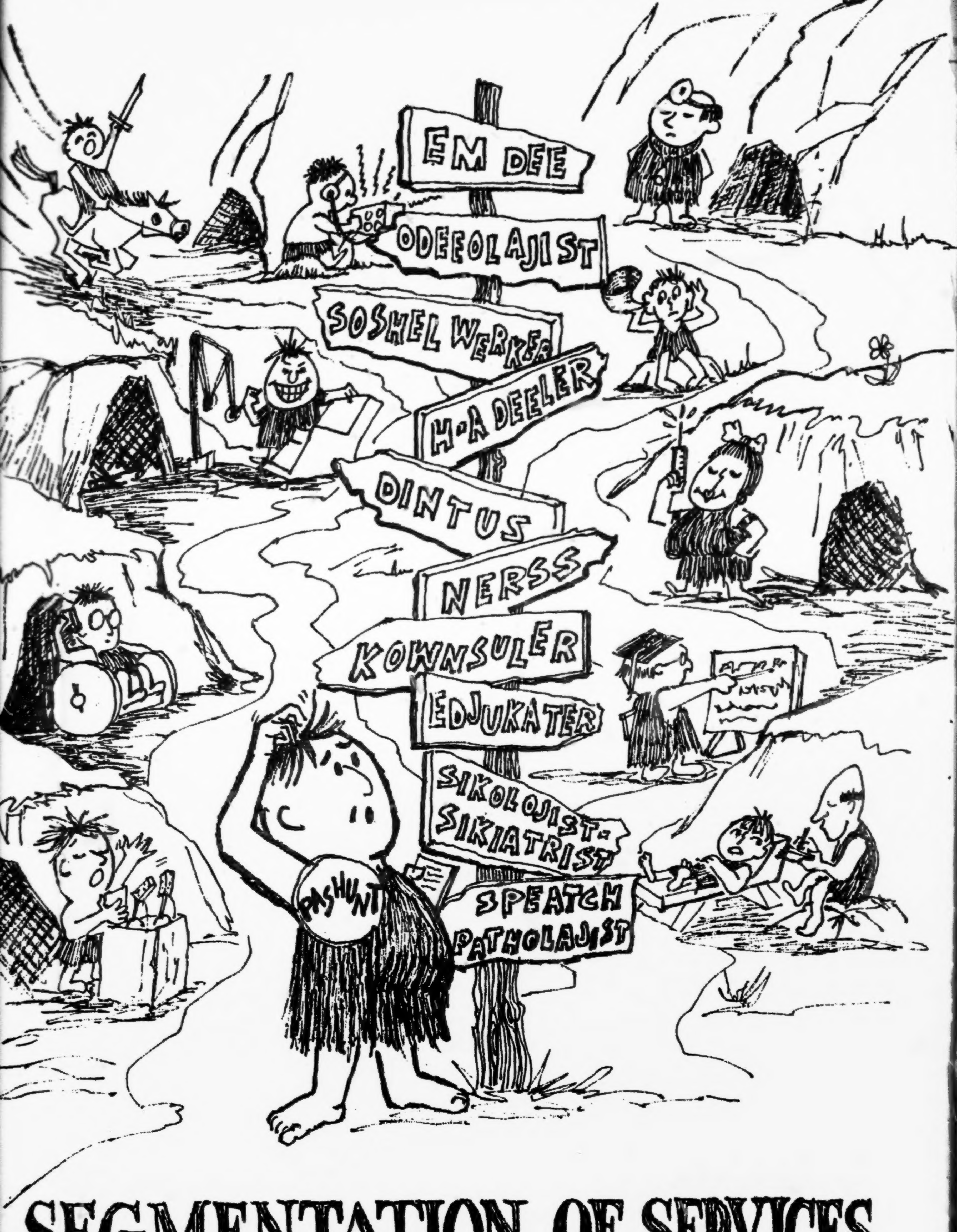
NEED FOR INTERDISCIPLINARY PROCEDURES

NEED FOR INTERDISCIPLINARY PROCEDURES

At times it has seemed that the approach to communication disorders has resembled the story of *The Blind Men and the Elephant.* Each discipline has looked at the "animal" from his own viewpoint and often the diagnosis, prognosis, referral, and treatment have had little in common with the concept of comprehensive habilitation or rehabilitation of the individual.

The Joint Committee on Dentistry and Speech Pathology-Audiology (1967) has prepared a statement concerning the importance for the interdisciplinary approach for these particular health services:

> Comprehensive patient management, whether viewed at the levels of direct service, professional preparation, or process and basic research, cannot be the exclusive concern of one profession. Historically, the two professions of Dentistry and Speech Pathology-Audiology have developed separately and uniquely. The one, Dentistry, traces its genesis to the proprietary school; its prototype was the independent, individual clinician in private practice. The other is a child of academia; its prototype was the salaried teacher-scholar-clinician. In both professions, growth has been evolutionary. The dentist, looking beyond his technological competence, and the speech pathologist-audiologist evaluating his full clinical responsibilities, have discovered matters of mutual concern.
>
> This mutuality of concern, although real and valid, does not confound the separate identity of of each profession. But if the relations between the two professions are to become increasingly complementary, two goals must be kept as constant targets. First, the area and degree of interface must be explored and defined; second, techniques of bi-professional functions must be recognized.
>
> First, at direct service levels, peridontal disease does not usually involve the speech pathologist nor does childhood aphasia usually involve the dentist. Yet, in cleft palate, the orthodontist and prosthodontist seek to modify structure to facilitate normal speech production. And, in tongue thrust both professions may work both with cause and effect.
>
> On the level of professional preparation, total curricula will never be similar. But consideration of such processes as mastication, deglutition, respiration, and speech is relevant to both.
>
> At the level of research, the detailed physical structure of the amalgam is not interchangeable with operant theory. But investigation of oral sensory mechanisms, plastic implants, and oral-nasal air flow can well occur in either setting.
>
> The second goal is, in part, dependent on adequate definition, yet in turn, will redefine the definition. This goal is to study and, perhaps, develop efficient patterns of bi-professional interaction and function. Particularly crucial is the relative impact of planned separation of shared responsibilities. Variation in all respects may occur at different levels, with different problems, and in individual situations.


EM DEE
ODEEOLAJIST
SOSHEL WERKER
H-A DEELER
DINTUS
NERSS
KOWNSULER
EDJUKATER
SIKOLOJIST-
SIKIATRIST
SPEATCH
PATHOLAJIST
PASHUNT

SEGMENTATION OF SERVICES

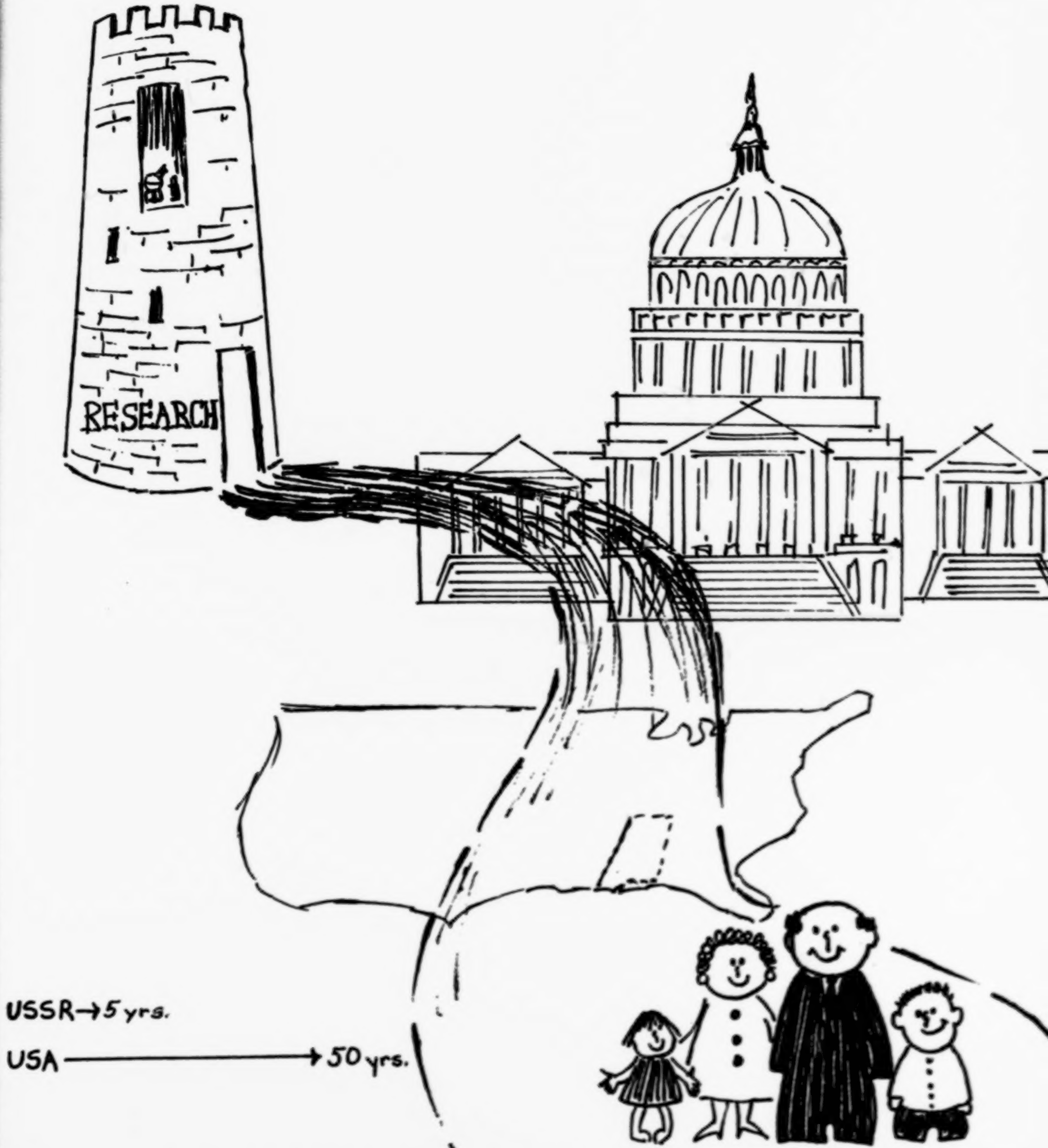
SEGMENTATION OF SERVICES

Dentistry and Speech Pathology-Audiology have not been the only areas in need of improved interdisciplinary communication. The medical profession and the psychosocial areas have come through some uncomfortable adjustments.

The patient many times has ended up the victim of segmentation of services which have effectively occluded the "real problem and appropriate solution." Some of the referrals conducive to an interdisciplinary approach, but which have often existed as isolated or discrete instance, have included the physician, the audiologist, the social worker, the hearing aid dealer, the dentist, the nurse, the rehabilitation counselor, the educator, the psychologist and psychiatrist, the speech pathologist, and others. The confusion has not been solely on the part of the patient, who has often been in a first-class quandary as he wandered from specialist-to-specialist, but also on the part of many of the professionals themselves.

The "image quandary" has perplexed professionals and their professions. We have been told that whenever the differences between the real self — the self as seen as by the person himself — and the self seen by society display pronounced differences, related degrees of maladjustment occur. Many new disciplines suffer from "image dislocations."

I feel that as speech pathologists and audiologists we have felt insecure in regard to what our "real image" should be and what our "real professional responsibilities" entail. I think we may have been sometimes too reticent and at others too confident in assuming a professional stance. Our multidisciplinary image has reflected our quandaries, and it has contributed to the confusion already inherent in the over-defined or under-defined images of other professions. Many personal and professional images among the medical - dental and psychosocial clinical areas have required definition and refurbishing, but I think we can safely say that distinct progress has been made and the end result has been better service for the patient.


RESEARCH
USSR→5 yrs.
USA→50 yrs.

LEAD TIME: LACK OF INTRA-INTERDISCIPLINARY COMMUNICATION

CENTRAL — NOT PERIPHERAL

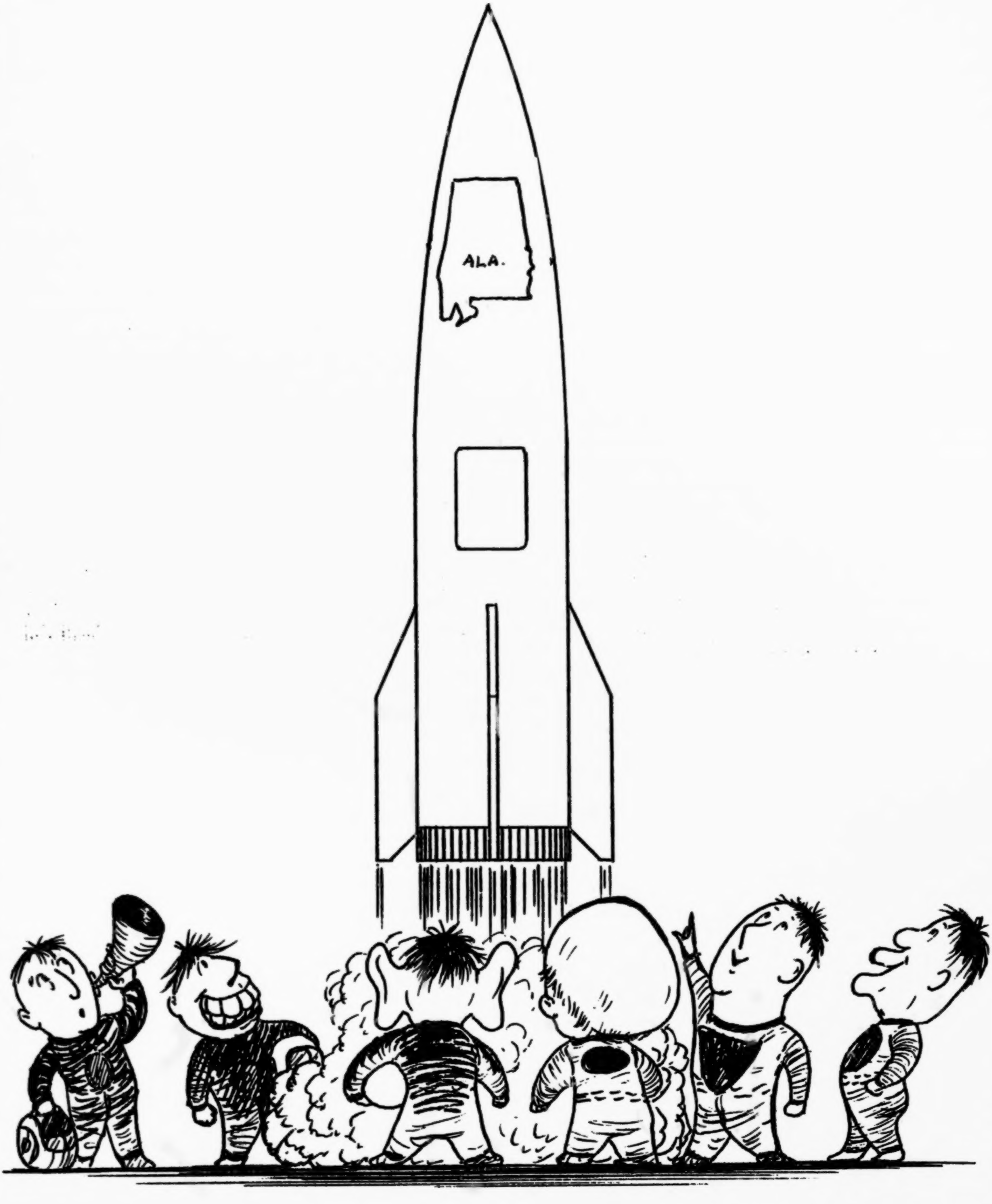
In the past, Speech and Hearing Services have nearly always operated from a position peripheral to the other health sciences. As a result of this distal relationship, treatment of speech disorders has assumed a *post*-curative attitude. Emphasis has been placed upon the "disordering" of speech and little attention has been paid to other facets of aberrant oral achitecture, muscular dysfunctions, and habit mechanisms and their role in the integral picture of the treatment of the whole person.

As speech pathologists and audiologists begin to function from a *pre*-curative attitude, their position becomes one interjacent to medical-dental and psychosocial clinical areas and is clinically augmentive to diagnosis within the total health picture. Their role becomes the synthesis of multidisciplinary knowledge and interdisciplinary experience with the responsibility of a *central*, not *peripheral*, discipline dedicated to the comprehensive programs of effective patient treatment.

LEAD TIME

Because of inadequate *intra*disciplinary and *inter*disciplinary communication, the Lead Time — that gap of time from the discovery and understanding of the treatment of a health problem to the time in which the professionals begin to apply their knowledge to the patient — is greatly lengthened. Dr. Ruth Clark of Denver University, after a trip to Russia, reported that the lead time in U. S. Education has been estimated at 50 years, while in Russia it is considered to be only 5 years (Chauncey).

Some hope for a reduction in Lead Time may be found in the Findings and Declaration of Purpose of Public Law 89-749, Section 2 (1966), which includes the statement that "Congress declares that fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living."



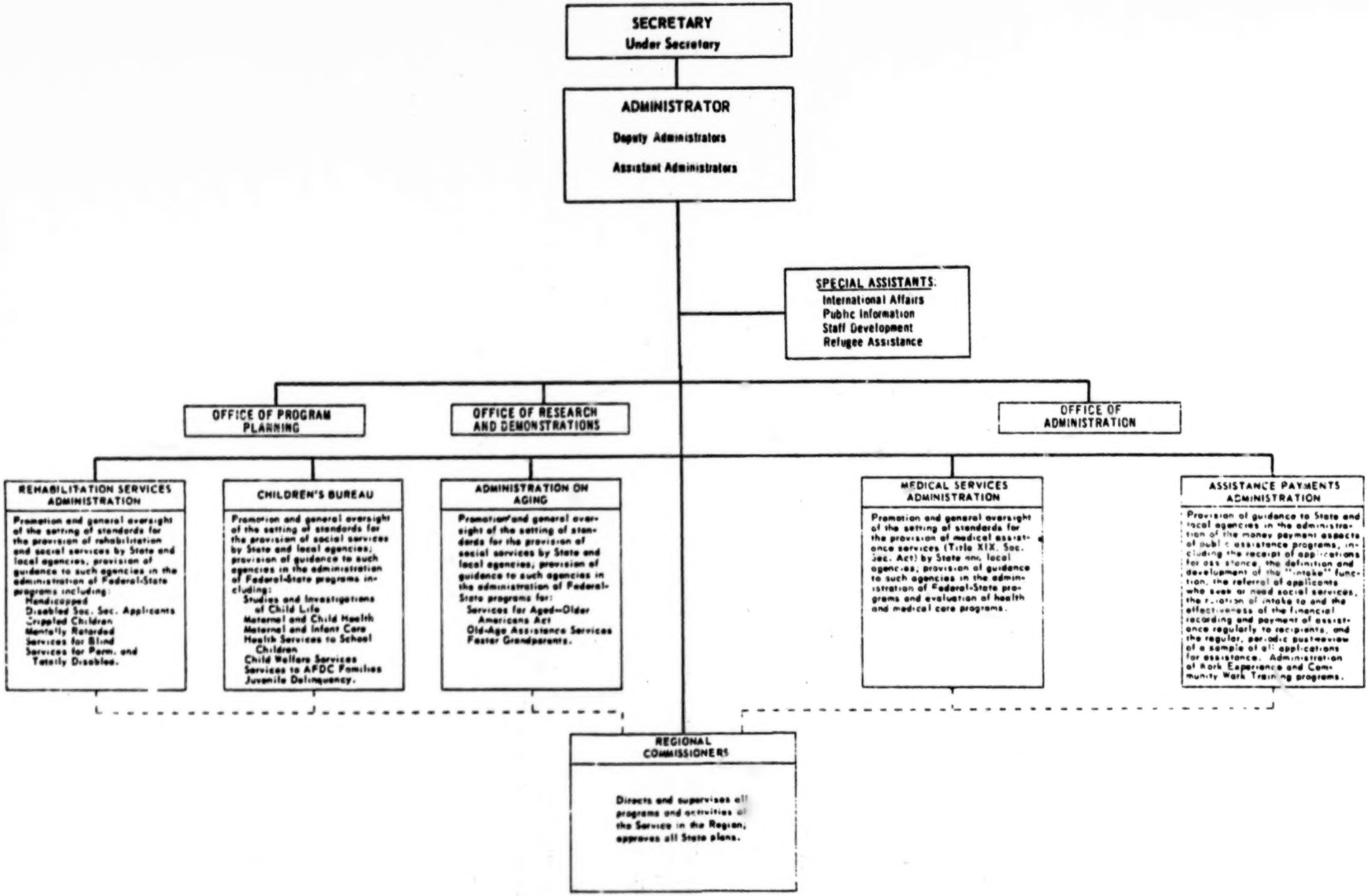
POWER OF AGENCY INTERACTION

Dr. William H. Stewart, Surgeon General of the Public Health Service, spoke about comprehensive health planning at a National Health Forum:

> No one has yet declared that happiness is a warm comprehensive plan. With that exception, there are very few things that have not been said about planning in recent weeks and months. To some, planning is a great white magic — a kind of touchstone that will suddenly plunge us into the best of all possible worlds. To others it is a dark menace, a threat to liberty and the inalienable rights of the individual.
>
> In fact, planning is neither magic nor menace. It is not magic because there is no guarantee that it will be done well and still less assurance that even the best-laid plans will not go agley, as Burns said, during the difficult translation into action. It is not a menace to liberty because planning itself dictates nothing — it merely proposes reasoned courses of action.
>
> Why all the fuss, then? Why plan at all?
>
> The most direct answer to that question is that our aspirations — for the individual and for society — have soared beyond our resources for fulfilling them. Whenever aspirations exceed resources at any point in time, choices must be made and priorities assigned. The planning process furnishes the basis for making choices among alternatives.
>
> Planning begins, therefore, with the aspirations of society. The first step is to articulate these aspirations into meaningful goals. In the United States today, our society aspires to the fulfillment of each individual. Heath, as a fundamental condition of self-fulfillment, ranks very high in the scale of societal values. Our health goals, therefore, must be set very high indeed.
>
> Once a set of goals has been agreed upon, the second step in the planning process is to break these down into a set of objectives — definable targets toward which we can aim specific efforts. Each objective, insofar as possible, should be measurable so that progress can be intelligently assessed.
>
> [The words of Congress] are overwhelming words to anyone who is comfortable only when health is narrowly defined. The Congress is speaking not merely about the prolongation of lives and the reduction of disease but rather about the highest level of health attainable. It is speaking about an environment that is not merely free of specific hazard but one which contributes positively to individual and family living.
>
> No lesser goal would be acceptable in today's America. No lesser goal would be consonant with the aspirations of the American people.
>
> Health resources, as we have traditionally defined them — the private and public providers of services, the agencies with the word "health" or "medical" in the title — cannot possibly attain this goal if they work apart from each other or apart from other social forces.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Social and Rehabilitation Service


SECRETARY
Under Secretary
ADMINISTRATOR
Deputy Administrators
Assistant Administrators
SPECIAL ASSISTANTS:
International Affairs
Public Information
Staff Development
Refugee Assistance
OFFICE OF PROGRAM PLANNING
OFFICE OF RESEARCH AND DEMONSTRATIONS
OFFICE OF ADMINISTRATION
REHABILITATION SERVICES ADMINISTRATION
CHILDREN'S BUREAU
ADMINISTRATION ON AGING
MEDICAL SERVICES ADMINISTRATION
ASSISTANCE PAYMENTS ADMINISTRATION
REGIONAL COMMISSIONERS

REHABILITATION SERVICES ADMINISTRATION

Promotion and general oversight of the setting of standards for the provision of rehabilitation and social services by State and local agencies, provision of guidance to such agencies in the administration of Federal-State programs including:
- Handicapped
- Disabled Soc. Sec. Applicants
- Crippled Children
- Mentally Retarded
- Services for Blind
- Services for Perm. and Totally Disabled.

CHILDREN'S BUREAU

Promotion and general oversight of the setting of standards for the provision of social services by State and local agencies; provision of guidance to such agencies in the administration of Federal-State programs including:
- Studies and Investigations of Child Life
- Maternal and Child Health
- Maternal and Infant Care
- Health Services to School Children
- Child Welfare Services
- Services to AFDC Families
- Juvenile Delinquency.

ADMINISTRATION ON AGING

Promotion and general oversight of the setting of standards for the provision of social services by State and local agencies, provision of guidance to such agencies in the administration of Federal-State programs for:
- Services for Aged—Older Americans Act
- Old-Age Assistance Services
- Foster Grandparents.

MEDICAL SERVICES ADMINISTRATION

Promotion and general oversight of the setting of standards for the provision of medical assistance services (Title XIX, Soc. Sec. Act) by State and local agencies; provision of guidance to such agencies in the administration of Federal-State programs and evaluation of health and medical care programs.

ASSISTANCE PAYMENTS ADMINISTRATION

Provision of guidance to State and local agencies in the administration of the money payment aspects of public assistance programs, including the receipt of applications for assistance, the definition and development of the "intake" function, the referral of applicants who seek or need social services, the relation of intake to and the effectiveness of the financial recording and payment of assistance regularly to recipients, and the regular, periodic postreview of a sample of all applications for assistance. Administration of Work Experience and Community Work Training programs.

REGIONAL COMMISSIONERS

Directs and supervises all programs and activities of the Service in the Region; approves all State plans.

SOCIAL AND REHABILITATION SERVICE

One of the major changes in the HEW structure and programs involves the formation of the *Social and Rehabilitation Service*. This agency "has been established to carry out the functions of the Welfare Administration, the Vocational Rehabilitation Administration, the Administration on Aging, and the Mental Retardation Division of the Bureau of Health Services, Public Health Service" (*Washington Sounds*, 1967).

About 7.6 million persons (four percent of the population) receive cash assistance at any given time under Federally-aided programs. These payments total about $4 billion annually, of which 62 percent comes from the Federal Government, and the balance from state and local governments.

Almost 175,000 persons are rehabilitated for gainful employment each year through vocational rehabilitation programs.

Over 6 million needy persons receive medical services each year through Federally-assisted programs, including the new Title XIX Medicaid program.

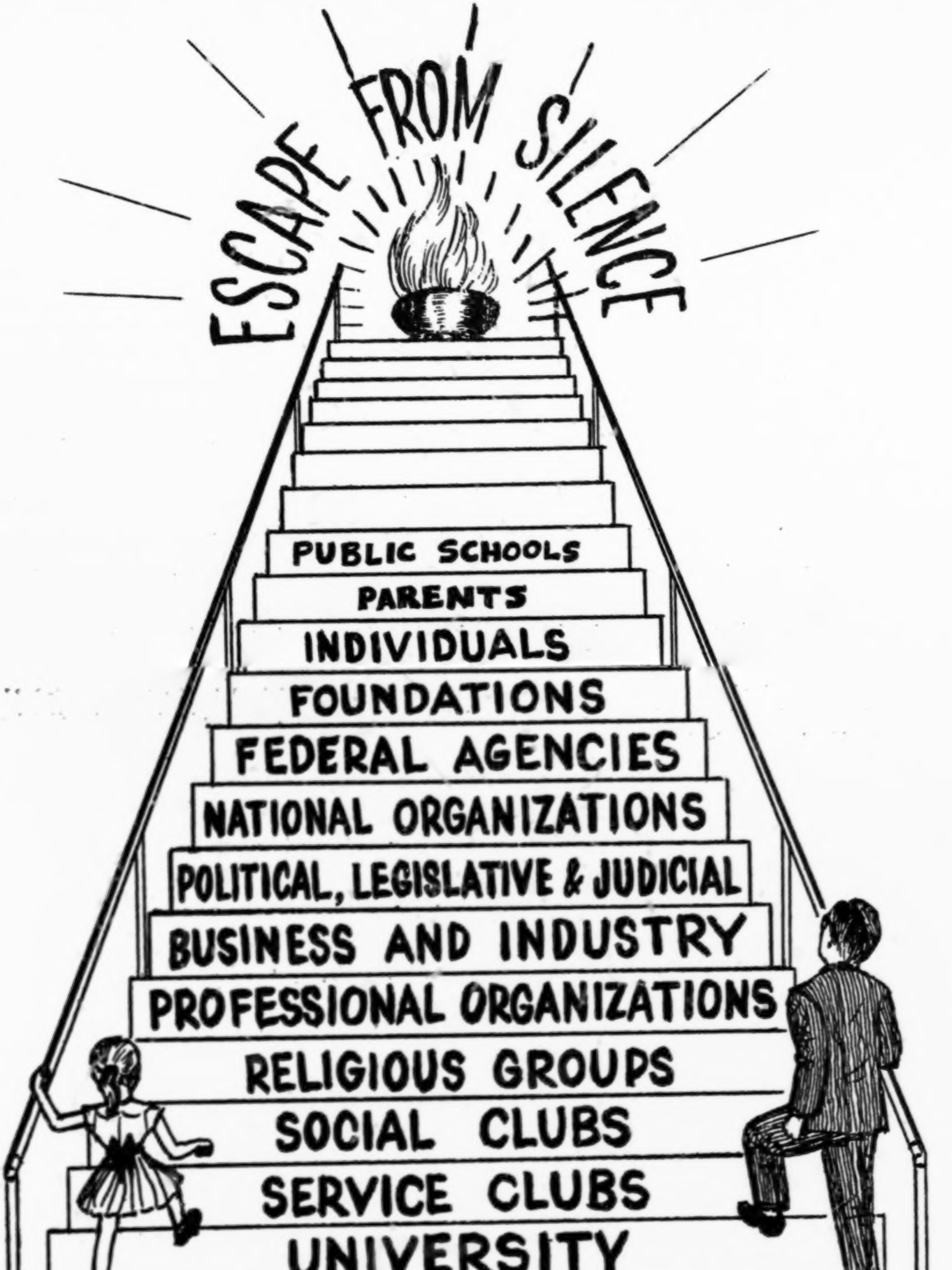
Over 600,000 children receive child welfare services related to adoption, foster care or neglect.

Over 450,000 crippled children receive medical services each year with Federal assistance.

More than 250,000 women received family planning help last year through Children's Bureau programs.

More than 700 projects assisted by the Administration on Aging provide services for many of the 19 million Americans over 65.

The combined 1967 appropriations of the HEW components joined in the SRS totalled $4.8 billion in Federal funds. The new Agency would have about 1,900 employees in five major divisions (*Washington Sounds*, 1967).


ESCAPE FROM SILENCE
PUBLIC SCHOOLS
PARENTS
INDIVIDUALS
FOUNDATIONS
FEDERAL AGENCIES
NATIONAL ORGANIZATIONS
POLITICAL, LEGISLATIVE & JUDICIAL
BUSINESS AND INDUSTRY
PROFESSIONAL ORGANIZATIONS
RELIGIOUS GROUPS
SOCIAL CLUBS
SERVICE CLUBS
UNIVERSITY

COMMUNITY ENDORSEMENT

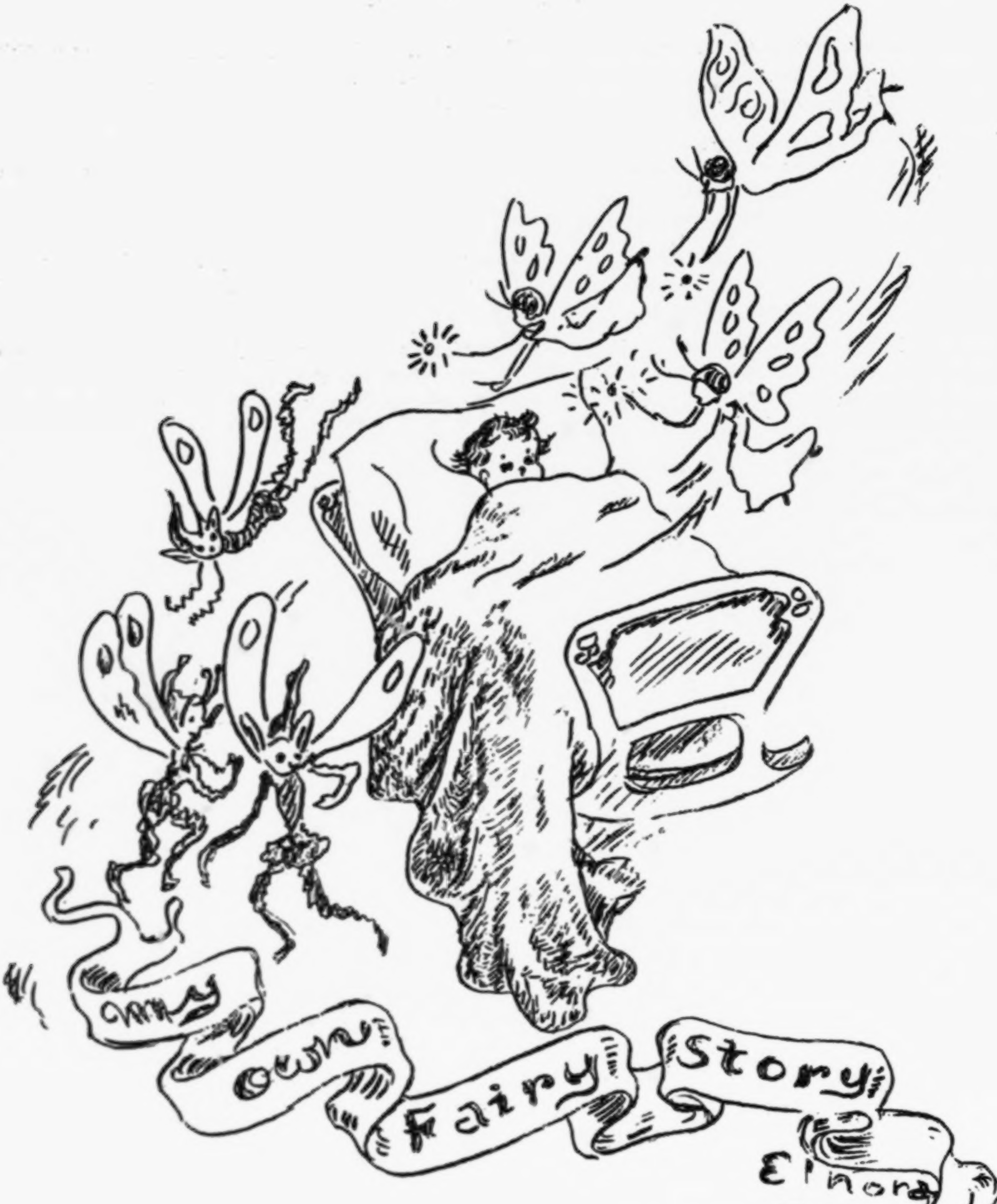
COMMUNITY ENDORSEMENT

The numbers of persons involved and the amount of funding required for the new SRS Agency strain the comprehension. To become meaningful, the figures have to be brought down to the local level and interpreted in light of community endorsement.

The reorientation of new and present knowledge in the medical-dental and psychosocial disciplines for the diagnosis and treatment of communicational disorders demonstrates the need for a confluent communication discipline built upon the tenets of speech pathology and audiology and bulwarked by the most recent advances in medicine and dentistry.

The staff of Aescuylapius becomes more meaningful if it is interpreted to be the symbol of the total health picture which has progressed from the *undisciplinary* through the *multidisciplinary* to the *interdisciplinary* approach.

Programs abounding in funding and philosophy become meaningful, only in terms of the individuals they serve. Elnora, a recipient of many of these services because of profound deafness, near blindness, dwarfism, cleft palate, and no formal education, tells of her own experiences with the helping professions in *My Own Fairy Story.*


my own Fairy Story
Elnora Cheney

MY OWN FAIRY STORY

I have always loved fairy stories, and I would like to tell you one tonight. They say real life is not like a fairy story, but it has been for me.

My story begins just like a fairy story, with a little cabin in the woods where a very poor man and his family are watching over a tiny new baby in a cradle. Inside the cabin all is warm and cozy, but outside the snow is falling. A sudden gust of wind blows the door open and unseen by the family a band of bad fairies enter, bringing with them gifts for the child, but these are evil gifts.

"She is so little," one says, "that we must not crush her with too heavy a burden, for it has been decreed that she shall live. My gift for her is blindness, only I will let her see a little, that she may save herself from death."

"My gift," says a second, "shall be deafness, only I shall let her hear just a little."

"And mine," a third says, "shall be poor speech that a few may understand her, and she shall have no beauty, except her hair."

"With the deafness I shall form an invisible wall around her, that she may have no friends; only a few shall get through," the last says.

Then the sun came out and the good fairies came in through the window on a sunbeam, chasing away the bad fairies with the storm. As they gathered around the cradle, one of the good fairies said, "We cannot undo what the bad fairies have done, but we can give her love of beauty, that what little she sees may be beautiful to her eyes, and she shall create beauty for herself and others."

"My best gift," said another, "shall be understanding, that what little she hears she will understand, and she shall have an understanding heart for the troubles of others."

"And mine," said the last, "shall be love of books, that the great minds of the ages shall be her companions and counselors, and what few friends she does have will be good people who will do great things for her. It will be through these friends that the bad fairies' spell shall be broken, for while we cannot do this, they can."

Now, all the things the fairies said came true, and the little girl grew up much as did the Ugly Duckling in another favorite story. You will recall how the mother duck protected and guided her little one, and how she resented the criticism of the other farmyard folk. Even so did the little girl's mother love her. Like the duckling, the little girl wanted to be like the others and to have friends. She was sent to a school for deaf and blind children, but even here she could not be like the others, so she was sent home.

Having learned to read very early, she made books her companions and withdrew into the shelter of her home as in a walled garden, where she remained for many years, learning slowly to create works of beauty.

One day some friends came to the gate in the wall with a small magic box, and with this in her hands the wall of silence crumbled and she no longer was alone, for now others who wanted to be friends were able to tell her so. One man's kindness enabled her to earn her living and become self-reliant, and another man came with the gift of good vision, though he lost part of his gift on the way, so that there was only enough for one eye. They are still looking for the lost vision.

One day a lovely golden-haired woman appeared suddenly before her and said, "Come with me." Now this lady was really a great magician who knew all about what the fairies had done, for she was a friend of the good fairies. So they went away together to an enchanted city, where the little girl, now a woman grown, was taught to speak more clearly and sent to school with other ladies.

One day a magician said to her, "In your heart you are wishing for one thing more; what is it?"

"I do not know," said the woman. "I would know it if I saw it, for it has something to do with beauty."

So the magician sent her out to search the enchanted city where she met a wise woman who told her, "Go and knock on a certain door."

She did so and when it was opened she found herself in a sculptor's studio presided over by a magician disguised as a swan who knew all there was to know about beauty and how to create it. There she has lived ever since, making dreams come true.

Let me conclude this little tale by going back to the story of the Ugly Duckling. When I look in the mirror I see that I am still a duck, but a duck with glossy feathers and something to quack about, for I find myself tonight surrounded by beautiful swans who have made me welcome and accepted me as a friend.

Elnora Cheney

(Text of an "ice breaker" speech given at a meeting of the Pocatello Toastmistress Club on September 21, 1964.)

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ORAL ARCHITECTURE AND EXPRESSION POTENTIAL

Joseph M. Sims

The verbal expression potential of individuals in terms of excellence of speech during childhood, and adequate recovery following a loss or impairment of speech after maturity, has been quite well studied in many areas. Some of these studies have been based on neurological data, psychological data, or studies showing the importance of the anatomical loss of oral tissues by disease or trauma.

Studies of the oral architecture as it affects the production of speech sounds, except for the classical studies dealing with cleft palate individuals, have been perhaps less well done. We are in the position of having physicians and Ph.D.'s who are extremely well trained in anatomy and physiology. And we have dentists who have pursued studies in exquisite detail concerning the hard and soft tissues of the oral and peri-oral anatomy. These men are available and they are interested in aiding the speech pathologists with some of their most challenging problems. What is needed now, it is felt, is to train some speech pathophysiologists — speech people who understand the various specialties in medicine and dentistry — so that concerted efforts can be made to attack certain problems in patients. These problems seem to have overtones in medicine and dentistry, even though the main problem may be within the parameters of speech pathology.

When structural defects exist, *other* than those involving cleft palate individuals, there are remarkably few people who can guide the dentist and physician in assisting speech deficient people, who exhibit these speech deficiencies as a result of aberrant structures or anatomy in or about the oral cavity.

When one considers the substance of the other speakers' words here today — that socially acceptable oral expression is assuming a greater role than ever before in our society in aiding or preventing individuals in achieving their full potential in life — it behooves our speech physiologists to observe more closely, diagnose with sharpened skills, and be prepared in some cases to move closer to the disciplines of clinical medicine and dentistry. These possibilities are moving toward actuality much more rapidly than in the past, as specialists in pediatrics, ear-nose-throat, otolaryngology, neurology, pedodontics, orthodontics and prosthodontics pursue investigations to determine why their patients' speech patterns are abnormal.

It might be profitable for a moment to review tthe separate anatomical entities which together form the integrated whole that we call the oral architecture. Essentially, the fixed hard parts of the maxilla are designed to be met, and interdigitated with, the hinged mandible and its hard parts. Both the mandible and maxilla are covered with tough, highly vascularized, poorly invervated bibrous gingival tissue. Each horseshoe-shaped alveolar ridge, which support the teeth, are surrounded by sheets of strong skeletal muscle. Acting within the hollow-formed by these two padded jaws is the active bundle of muscles called the tongue.

The tongue serves to taste foods, as an aid in mastication, assists the individual to swallow, actis to cleanse the mouth and teeth of food debris — and, of course, facilitates speech. Because it is such a strong muscle, the strongest for its size in the body, it has been said, excepting the heart, the tongue can also by its forceful actions, modify some elements of the oral architecture.

In fact, one way the elements of the oral architecture might be viewed is the ease with which they may be shaped or modified, both by muscular or habit forces as well as by intervention of the surgeon or dentist. An outline of the structures and their comparable ease of modification might be as follows:

Easily modified are:

1. The bony hard palate, including the gingival covering and rugae.
2. The alveolar ridges, including the attached gingivae.
3. The dentition, natural and artificial.

Not easily modified are:

1. Tongue.
2. Soft palate (velum).
3. Labial (lip) musculature.
4. Buccal (cheek) musculature.

The modifications spoken of here can be surgical, orthodontic, prosthodontic, or, indeed, even traumatic. They can also be the result of aberrent muscle patterns, as well as retained infantile habits such as thumb sucking, tongue thrusting, and others. The judgement of whether these anatomical changes are beneficial in the light of the patients' speech can be best rendered by speech professional working *with* the physician or the dentist.

In the case of the tongue, soft palate, labial musculature and buccal musculature — these can be modified by training, much better than by changes in anatomical or structural relationships.

Why are we speaking of modifications? Because, unfortunately, in the growth and development process, some individuals appear to go astray. Perfectly normal parts are used improperly, and, under abnormal muscular or external pressures, become deformed. Sometimes development itself is abnormal. In regarding development as abnormal, we are concerned here with the elements of oral architecture which when they become deformed do not allow normal speech production.

In showing the color slides which we should observe that these are genetic factors at work, as well as the results of oral habits, surgery, trauma, or disease. In some of the following cases combinations of these are present. Observe particularly the aberrancies of the oral architecture wrought by these habits, deviate swallowing, and abnormal muscular pressures. In many of these patients there are substantial speech deficiencies which, it would seem, might fail to be corrected by speech therapy procedures only.

Slides shown as follows:

1. *Perfect dentition, child and adult.* Before looking at abnormalities in oral architecture, it is best to reaffirm in our minds what is considered *normal.*

2. *Heavy maxillary labial frenum.* A heavy frenum is rarely a cause for concern in children's speech. It may, however, need to be resected if the child undergoes orthodontic care.

3. *Diastomata.* These spaces between the teeth usually close naturally.

4. *Excessive overjet associated with a tongue habit.* Orthodontic care can help here — speech patterns are not clear cut in these cases.

5. *Excessive overbite.* Orthodontics can also aid this child. Speech patterns are evident in some of these cases.

6. *Excessive overjet and overbite.* This is usually associated with both deviate swallowing, hypertensive mentalis muscle action, and thrusting of tongue during speech.

7. *Anterior open bite.* This is commonly associated with deviate swallowing and aberrant tongue position at rest, preventing normal eruption of upper and lower anterior teeth.

8. *Anterior open bite.* Tongue position seems to have caused most of the problem here.

9. *Anterior open bite.* In this case the open bite seems to be perpetuated by the thumb sucking habit (and hair pulling at the same time). This child can suck either thumb and pull either pigtail.

10. *Overjet.* Here associates with hypermentalis activity. Essentially, this allows the upper anterior teeth to remain in the same position while the lowers are pushed back toward the tongue.

11. *Oral habit.* Lip and cheek licking. This a long-lived problem which may have psychological implications.

12. *Tongue thrust appliance made by a dentist.* This is a classic case of misdiagnosis. The child was not a tongue thruster.

13. *Tongue thrust appliance.* This is a patient who probably neede psycholtherapy, speech, therapy, and orthodontic care, in that order. By intervening this dentist created a psychological crisis in the child.

14. *The American ideal of beauty.* These three slides show the American female in Angle's Class I, Class II, and Class III malocclusions. Strangely, while the Class I facial profile is sought after by orthodontists in their therapy procedures, our female ideal is the Class II profile.

15. *The American ideal of beauty.* These three slides depict the American male in Angle's Class I, Class II, and Class III malocclusions. Again, strangely, while the goal of dentists is Class I, the American ideal of a handsome profile is more nearly Class III.

16. *Varying palatal architecture in normal individuals.* These are several slides showing variations from normal in palatal architecture and yet all of these individuals exhibited normal speech.

In reviewing the roles of specialists as they work to improve speech deficient persons it is interesting to look at some *team* efforts. One quite recent study was accomplished by an orthodontist and a speech pathologist. It concerned 15 children who were tested and found to have between 5 and 16 defective speech sounds each, and who each needed orthodontic are. Speech therapy was initiated during the orthodontic treatment, At the end of the orthodontic therapy the children were tested again. The number of incorrectly made speech sounds were tested and ranged from zero to 4 for each child. In this study, obviously, the dentist and speech therapist, working in concert, accomplished their professional goals. The orthodontist succeeded in normalizing the oral architecture and the speech therapist brought all the children's speech into a range of social acceptability.

In a real sense, this outlines an approach for our mutual specialities in dealing with speech problems of children. It reinforces the "whole child concept" so well stated by Dr. Daniel and Dr. Vaughn.

What a refreshing atmosphere this could be in the investigation, diagnosis and treatment of speech problems if the specialists in speech could view their field, not as *peripheral,* but as more nearly central to the whole child's healthy adjustment to society during his growth to maturity.

Interested physicians, dentists, and speech pathologists are ready to help with their contributions. The challenge is here. Let us pledge a share of our efforts so that our patients, clients, or whatever we may call them, will benefit from the united richness of our knowledge in speech pathology, medicine and dentistry.

COMMUNICATION PROBLEMS AS RELATED TO READING ACHIEVEMENT

Miss Martha Black

We recognize increasingly the total involvement of personality in the meaningful development of communication. Personal experience must precede any understanding. While all the senses may participate in the acquisition of this experience, auditory and visual perception perhaps are the most important ones. The newly acquired knowledge is transferred to the brain where somehow it is organized and when the impulse, the need, to use it occurs, the idea is revealed to the outside world either through non-verbal action or through speech. Very early a baby learns to appease his hunger by reaching for the bottle. A frown from a teacher conveys the idea of no, or stop. Much communication is carried on by body movements, but we here today are concerned primarily with verbal communication. We are studying speech, how it grows and how it is related to reading. We have all heard the old story of the mother who approached a noted educator saying, "At what age, sir, do you recommend I begin the education of my boy?" "How old is the boy?" "Five years." "Rush home, Madam, you have already missed four and one half of the most important years."

If a child is going to use speech efficiently and if he is going to read for profit and pleasure, he must participate continually in experiences which lead him to new ideas and which give him the glow of satisfaction which comes from desirable accomplishments.

Let us consider the speech and reading development at various age levels.

First, the pre-school child. In this age of automobiles, motion pictures, radios, and TV, the home as an institution is no longer the strong lifelong influence it was in pioneer days. There is still one member of the family, however, for whom the home is as important as ever, perhaps even more so in view of the increasingly complex society for which he must be prepared. That member is the pre-school child. On him during those first years, each individual in the family group sets his own particular stamp. At the end of this period the child's personality pattern is the result of contacts with other people, modified, of course, by his intelligence and his physical health. And pushing in on him are the radio and TV — blasts which fill every home during all hours. I was amazed the other day when I asked my four year old grandniece where her four week old sister was and the answer was "In her TV chair." A canvas, hammock-like little chair, and it was on the floor in front of the TV.

While I do not wish to imply that much is not learned from the TV, our children of today are in many ways more sophisticated than those of previous years, but the problem is that this type of learning is all vicarious. The child is not actively participating. And real growth occurs only when the child himself becomes a part of the situation. So I expect more and more efforts must be made by parents and others who rear young children to give them opportunities to participate in activities.

Our modern life has brought more than gadgets to make physical labor less onerous and lotions to make us smell like roses. It has brought, also, the necessity for mothers to work away from home; it has forced families to leave localities where they have lived for generations and where they know their way about and to move to highly industrial centers where jobs are available, but where the age old family mores are totally inadequate in meeting city life. Modern automation has not only given the worker more leisure but it has also created a vast group of unemployed and often unemployable persons. So the problems of the pre-school child either in the home or in the child care center multiply.

One might say that reading skills begin to develop when a child learns to talk — 18 months — so we teachers have a vested interest in what happens to a very young child. In a very few years our skills as teachers will be measured by how well the child responds to our efforts. Whether or not the education of the pre-school child is the responsibility of the public schools is an unresolved question. In the main this work is being done through private agencies and often with the help of the federal government. Whoever is in charge of a nursery school program, a head start program, or what have you, she should be keenly aware of the need to give the child many experiences which will furnish him food for thought and provide opportunities for him to talk and to be listened to respectfully. Let his speech affect his environment. Have something happen because of his speech. That is the first step toward reading readiness. His auditory discrimination must be developed by making him aware of sounds, their difference, their meetings. His visual powers must be developed by giving him chances to observe gross likenesses and gross differences. For some few children it is through the sense of touch they learn to talk. One non-verbal child was finally helped to develop some speech by the use of modeling clay. After days of messing around, he produced something that vaguely resembled a boy. The teacher said "boy". The child grinned and said "boy". They went on to make a ball, a bed, a chair, and so he finally had a small but usable vocabulary.

The person working with young children must be aware of their need and love for action. Effective teaching is done during hopping, skipping and jumping. Children love rhythm — marching, swinging arms, beating drums, are all avenues leading to speech and to reading readiness. We remember that the large muscles must be trained before the finer coordination can be established.

Now let us think about the kindergarten child. The teacher here plans many activities which are aimed at teaching the child to follow directions, to think through a sequence, to see relationships — likenesses, differences; bigness, smallness; up and down; in and out; under and over; fat and thin; and so on. Again, auditory discrimination is trained, with the degree of differences being less gross than on the nursery school level. Visual observation is stressed. "Tell us what you see." Physical activities continue to give exercise to the large muscles. There may be more structured activities, such as marching games or simple folk dances, than are used with the pre-school children. Rhymes and songs sometimes accompany those games. Children act out simple activities; cats chasing mice, horses in a field, good-humored man selling ice cream, or buses, trucks and cars on a busy street, maybe the fire engine comes by — so on. Plenty of meaningful noise. Then there is quiet listening with the eyes closed and later telling what is heard. Formal reading is not started although the recognition of signs and names may be taught. The child's reading readiness program is increased, opportunities are given to verbalize what he hears, sees, and feels; new experiences are bringing an increase in his vocabulary.

Should the speech correctionist take the first grade children who have defects? That depends. First, have they had a kindergarten experience? If not, wait and see what a semester at school does for their speech. Next, how serious is the problem? *Th* off—a few substitutions? Wait, particularly if you have more upper grade pupils than you can serve. Does he stutter? Yes, begin working. It may be primarily with the parents and his teacher. Voice problem? Get a good physical examination by a competent doctor. Greatly retarded speech? Yes, you had better make a case study and begin work. You may want to give the classroom teacher some help in the speech improvement work. While this is primarily the responsibility of the classroom teacher (and more and more colleges are preparing elementary teachers for this work), you may help her by giving suggestions, introducing materials, loaning filmstrips, etc.

I trust first grade teachers in Alabama do not attempt to begin reading on the same day with every child. I trust classrooms are small enough so there may be some divisions within each grade. No child should have reading forced upon him until he has a fairly good command of oral speech. Can he tell a simple story and keep the sequence straight? Does he know some nursery rhymes? Does he recognize visual differences — long lines, short ones, round and square, etc?

The primary child has various problems. I believe it is Lucille Harrison who suggests the following:

He may be ill at ease in a new social situation. Perhaps he has talked only to adults, so among his peers his big words and long sentences mark him for ridicule. Possibly he comes from a home of very different social and economic level. His experiences have not prepared him for the group he is with.

The child may use baby talk or a private language. The teacher must help him to learn the speech of the school. I do not follow the suggestion I've heard comes from Washington about doing nothing about dialectal or sub-standard speech in Head Start pupils. Better speech can be taught tactfully and kindly. But how much of a Head Start will these children get if you go on perpetuating poor speech?

A child may have articulation problems. We have mentioned that.

A child may not understand the language used by the teacher. Watch out for that. Be sure you are understood. Of course, you are building vocabulary. (Moses and the bull rushes.)

These are all points for the teacher to observe.

Then, too, the first grade child needs a frequent change of position and pace. He, too, needs activity and can be taught while moving about — rhythms, chants, etc.

Children of six and seven are largely individualists. They are interested in themselves. The here and now are important. In preparing reading charts or in creating speech materials, this truth should be kept in mind. The speech correctionist should know what the first grade teacher is doing. What script or lettering is used. What vocabulary is being taught. The first grade teacher should know how the speech teacher presents sounds. I fear many of our pre-primer and first grade teachers' manuals contain some grave errors so far as what sounds the letters make. I've not investigated them recently, but a few years ago the speech department at Bradley University made an extensive study of teachers' manuals. Many errors were found. (Dr. Clara Mawhinney's article, *Exceptional Child*, Feb. '59.)

The young child likes factual material. He wants direct, specific information. His thinking is quite concrete but he is gradually going into the more abstract concept. What is it? Why? And How? begin to pop up. Group activities start to assume importance.

The primary teacher and the speech correctionist should work closely together. Each should know the plan of the other and dovetail their efforts. The approach to the *Sounds the Letters Make* should be the same. If *f* is the angry cat sound for one, it should be called that by the other. Of course, a child who is making very slow progress in either speech or reading should have a complete physical examination. Special attention should be given his hearing. The speech teacher should help the classroom teacher understand the hard-of-hearing child. After talking through the problems, the correctionist should give the teacher a copy of suggestions. Here is one I've found useful.

If a speech problem is present, the two teachers should pool their knowledge and design activities that are consistent, always remembering that speech must come before reading.

It has not been the practice for many years to devote much time to oral reading in the grades. Undoubtedly it was overdone fifty and more years ago yet I regret this trend. First, one of the most vivid memories of my childhood is the 15 minutes at the end of the day when, if we were good, Miss Flyn would read aloud. I loved it. "The Enchanted Garden," "The Five Little Peppers" — and we children were taught to stand on our feet and read so we could be understood. Yes, I know most reading is silent, and we are such busy people we have no time to sit and enjoy, but please let us have some oral reading. Oral reading is sharing ideas. Have the youngsters read reports, give directions, quotations, and then some recreational reading — just for the joy of it. Teacher should read to them, and they to her. I may be a bit prejudiced in favor of oral reading.

The rate of speech growth in general as well as in the overcoming of defects, and the rate of growth in reading skills, are both matters of individual development. While chronological age may still be the best single factor to determine the grouping of children, yet, as we all know, within any year of age range will be found a great range of achievement. And the achievement for a single child will not be consistent in all aspects of his learning. He may respond quickly to auditory stimulation and learn to make isolated sounds with the greatest accuracy, yet fail to get the sound into a word. He may learn to recognize words but be slow in recognizing sentence meaning. So on. A teacher of reading and a teacher of speech must teach the individual and plot the course of action to meet his need. Much help can come from observing one another work and from sharing knowledge.

And may I suggest here that staffings for puzzling cases are extremely valuable. Difficult as they are to arrange, I recognize that, yet they are valuable. Here the teachers involved — the classroom teacher, speech correctionist, psychologist, social worker, nurse, principal, and any other worker directly concerned with the child — get together to present the various opinions and to work out a plan of action. Not only is it helpful for the child, but also it is an excellent method for in-service training of all persons participating.

There have been studies which indicate that persons with certain speech defects are apt to be poor readers. First of all there would be the child with a hearing loss. If he misses much of what was said, his speech will have certain defects, and he will be a poor reader. Then the child with emotional problems which block his speech and, also, keep him from having a happy life and enjoying the experiences needed to make him understand and appreciate what the printed symbols say may be also a poor reader. The child for whom English is not his mother tongue will have reading difficulties until he masters the language. This, of course, is not a true speech defect, but a correctionist can give this youngster help which will increase his progress in acquiring the new language.

The work of a therapist in helping a hard-of-hearing child improve his speech and acquire the ability to read lips will undoubtedly help him read better. Work to give a disturbed child a more stable emotional life, to help him to accept what cannot be changed, and to make the most of his strengths, will have a positive effect on his reading progress. In all likelihood, both the classroom teacher and the speech teacher should work together on this child's problems. The plan should be a consistent one followed by both.

In the ages 9 to 11 social change becomes more significant than physical change. Now they have pals and groups are beginning to be formed. There are boys' groups and girls' groups. The opinion of the group is far more important than that of the home. A good teacher takes advantage of this. Have good group standards for reading. Achieve this through a reading club, a library committee, or a newspaper staff. In your speech correction, have speech clubs and speech pals. Use dramatization, radio skits and team games involving verbal activities. Interests are expanding and becoming more individual. Watch for this and feed a child those materials that are of greatest interest to him. These are the years he has time to read. Make the most of them. Again: speech growth and reading growth come when the outside stimulation is such that the inner self of the child reaches out for expression and finds that because the expression is effective there are rewards and joys in a greater respect for self. That is learning and maturing.

Betts has suggester, "Reading is a language process rather than a subject. In a psychological sense, reading is a thinking process. In another sense, reading is a "social process" that relates the reader to his environment and conditions that relationship. Psychophysiological factors, such as seeing and hearing, are also embraced by an adequate concept of reading as a process." Of all these processes Betts would emphasize most the idea of evaluation, or "of reconstructing the facts behind the symbols."

In his first chapter in "Speech Correction" Van Riper says, "Speech is a motor act," and he goes on to note the motor activity involved. Then he describes "Speech in Thinking" and says thinking is "covert symbolic behavior." It is covert because it is hidden, invisible, and private. It is symbolic since experience is somehow coded and transformed and translated into representative symbols. Finally, these symbols are bits of behavior." Note how close that is to Bett's idea of evaluation. Van Riper then talks about speech as communication and speech as social control. Again, this is exactly what Betts says when he calls reading a 'social process'. And finally, Van Riper speaks of speech as an emotional expression and as self-expression.

It is very interesting to note how both these authorities, one in reading and one in speech, agree on the fundamental processes of communication. Impulses must enter the brain through the senses. They must be organized within the brain, then come out in various forms of expression. Betts, of course, emphasizes the utilization of the printed page as a source for impulses and Van's job is to help straighten out the oral expression that is less than satisfying. But the chain of processes by which the very human activities of both reading and speech are developed are quite similar. That is why we find such a close relationship between reading and speech.

The child who stutters often presents a baffling problem to classroom teachers. While in most cases the stuttering will not affect his ability to read — in fact he may be an excellent reader because he has retreated into a world of his own and he spends much time with books — his oral communication, however, is greatly affected. The correctionist may help the classroom teacher understand this problem by discussing it with her, giving her certain books to read — or Johnson's "Letter to Mothers of Stutterers," Van Riper's "Your Child's Speech Problem." The Speech Foundation of America, 152 Lombardy Road, Memphis, Tenn. has a good booklet on stuttering — "Stuttering: It's Prevention." The National Society for Crippled Children and Adults, Inc. has a booklet by Wendell Johnson, "Toward Understanding Stuttering." A correctionist should have copies of these booklets on hand to loan teachers who are interested in knowing more about stuttering.

Working with children in the 12 to 14 years age group requires some changes in both reading and speech techniques. This is an age for much reading. The boys have interests in physical activities: the gang, hoarding and collecting. They like mystery and adventure—often series. The girls are a bit more mature. They read more than boys but it's novels, love stories, women's magazines. Individually, however, these youngsters may differ greatly and again it is of utmost importance for both the reading and the speech teachers to know each pupil. Speech correctionists have to prepare materials, the stuff which leads to speech, which meet the changing interests of adolescents. Be familiar with what is being read, know the social life of these pupils. How are these activities affecting their emotional life? And again and again, remember, each child is an individual. He will make no sudden jump on September 4th from pre-adolescense to adolescense. It will be a gradual process. Each at his own pace. As he grows he must learn to interpret, evaluate, and use what he reads. The mechanics of reading have been learned, now subject matter becomes more important.

Speech defects which have persisted until the high school period are well established and hence difficult to correct. Students of this age are apt to be very, very self conscious and may dislike having attention attracted to their speech by being taken from the group and given therapy. On the other hand, they are beginning to consider a more independent life. Either in college or on the job they will soon be on their own and this is a serious problem. Social life, too, is becoming increasingly important. They recognize that good speech is undoubtedly a definite asset. These considerations are powerful motivating factors.

While some youngsters who rejected help during their junior high school days will now seek it, others will need tactful counseling before they will recognize the value of speech training.

Although the basic philosophy and some of the techniques used with younger children are the same for older youngsters, yet because of the physical and psychological changes occurring during adolescense, activities which appear more sophisticated are required, and effective therapy, as well as effective teaching of reading (now possibly called courses in literature) must be attuned to needs of thes fledging adults.

High on the list of baffling problems is the adjustment of the adolescent, especially one with a speech difficulty, to school situations and environmental influences. Involved in this relationship are an adolescent's efforts to establish a self-concept as well as his desire for independence and freedom from the adult. Closely allied is the need for motivation, which must be approached in many different ways but always with sensitivity. If care is not exercised by the therapist, the personal nature of speech therapy may tend to intensify these hazards in relationships. The same danger lurks in the relationship of a teacher of emotionally charged literature and his students.

Changes occur during pre-adolescence (about 6th through 9th grade for girls and about 7th through 10th for boys) which make it impossible or unhealthy for a child to continue to be a ritualistic and compliant learning machine. During the early years most children respond readily to any learning situation. The child accepts the need for adult control and submits to it. Learning occurs readily in this early age because the child believes in magic. He believes that if he does all the things adults expect, his needs will be fulfilled. He learns skills for the same reason he enjoys jokes in the form of riddles and puns. The procedure gives him security because he knows all the answers. But this doesn't happen in high school.

If the teacher of high school youth continues to assume the compliance found in the younger child, she will fail to create the necessary motivation for integrated learning. The teenager may detest speech games. He wants to work and work hard, but he also hates to face or expose his problem. He is ashamed and embarrassed by it. It may be a stutter or it may be slow reading habits. The adolescent may attempt to escape the feelings he cannot handle adequately by throwing his energy into various projects (even into speech work) but the end product may tend to be meaningless if the activity is only an nescape. For instance, there may be no carry-over in speech correction. The student may practice his drills in speech class or fill his workbook at home, but he may be going through motions only as a form of escape. Ultimately, if normal development is to proceed, the adolescent must learn how to handle his new machine and the steam it generates. The impulses from the biological organism are too strong to escape from or to be solved magically by completing a book review assignment or by reading off a list of *s* words without error. Learning is not likely to hold up unless the desire for it was present before adolescence or is cultivated during this later period.

The adult independence toward which the adolescent is striving will be attained only as he discovers for himself the experiences which will give him self-reliance. He may refuse, however, to do what he himself knows is good because the directives have come from an adult. The motivation to accept new concepts has to come from within, carefully promoted by teachers and parents. The adolescent will work with an adult in order to learn a meaningful thing. This leads to identification with certain adults, provided they do not represent the authority against which he is so quick to rebel.

The therapist effects a change in speech patterns of teenagers for two inter-dependent reasons:

1) The need for change is recognized by the student.
2) The student can identify with the pattern of someone else — speech therapist or some other member of the group who has status outside the speech room.

High school students follow the stars. If you in your speech group or your literature class can have a leader — one everyone looks up to — and if you can win this leader — the others will follow. Each wants to be like the popular one. This peer identification is a mighty factor. May it be for what is good.

Let us summarize. In going over this paper, I felt I had performed somewhat like the Ladies Afternoon Literary Society. The Weekly Gazette reported that the ladies had met, discussed the works of Milton and Shakespeare, and adjourned for tea.

Well, we have attempted to show the similarity in the basic learning processes for all communication. Beginning with the pre-school child and coming up through high school student, we have indicated the various developmental stages and how teaching of both speech and reading must be adjusted to meet changing needs. We have tried to show how reading and speech are interdependent. To read well a child must first talk well. To talk well, he must have a background rich in experiences. These experiences begin in the cradle and continue through life. And above all, we have emphasized that each child is a unique individual and must be accepted as such.

And now I could do with a cup of the Literary Club's tea.

Thank you.

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